

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth ____/____/____

Phone: _____ Last four of SSN: _____

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other _____

I authorize the use or disclosure of the above named individual's health information as described below.

I hereby authorize records to be **released from**:

Records to be **released to**:

Name _____

Name _____

Address _____

Address _____

Phone _____ Fax _____

Phone _____ Fax _____

Disclosure method: digital hard copy fax mail Medical Clinic pick-up secure email _____

Type of General Medical Information to be Released

- Complete Copy of all Medical Records
- Physician notes and records (limited to two (2) years of information and excludes other protected records)
- Lab test results. Please specify tests and dates _____
- Imaging reports (X-ray, MRI, etc.) Please specify dates _____
- Electrocardiogram (ECG/EKG) reports
- Vaccine and Medication record
- Problem list
- Operative records (procedures done at the above clinic)
- Health information summary
- Other records or test results. Please specify information and dates _____

If the records to be disclosed contain any of the type of information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed **only if I initial in the spaces below**:

_____ HIV/AIDS Information

_____ Genetic Testing Information

_____ Mental Health Information

_____ Drug/Alcohol diagnosis, treatment and referral information

Release of the above information is limited to the following time period or treatment:

Expiration of authorization of Release (Required)

This authorization is valid for 90 days from the date of the authorization or until (specify date) ____/____/____ unless revoked by the patient orally or in writing at an earlier time. I understand I can revoke this authorization by contacting the Clinic Manager at the above named clinic. The only exception is when the Clinic named above has already taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

Disclosure & Authorization Signature (Required)

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or reimbursement for services except in the circumstance that the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without my knowledge or consent. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions, or genetic information.

Signature of Patient or Legal Guardian

Date