Patient Authorization for Disclosure of Protected Health Information

PATIENT: Legal Name: _____

IDENTIFICATION: Date of Birth: _____

Parents/Previous Name(s): _____

PROVIDER: (Who is releasing the information sent) Name: _____

Address: _____

INFORMATION TO BE RELEASED: (Check all that apply)

☐ Complete Medical Record ☐ Immunization Records

☐ Medical Records generated from the following treatment date(s) _____

☐ Specific Medical Records _____

☐ Billing Record(s)-please list _____

PURPOSE:

☐ Transferring Medical Care ☐ Moving

☐ Second Opinion or Specialty Care ☐ Workman's Compensation Claim (see special release form)

☐ Litigation ☐ Insurance Claim

☐ Other _____

Specific Authorization for Release of Information Protected by State or Federal Law

I specifically authorize the release of data and information relating to:

☐ Substance abuse (alcohol/drug) –***a separate authorization is required to disclose records from a federally-assisted substance abuse treatment program.***

☐ Mental Health (includes psychological testing and treatment) ****a separate authorization is required to disclose psychotherapy notes***

☐ HIV/AIDS test results ☐ Sexually transmitted diseases

INFORMATION SENT TO: Name _____

Address: _____

This authorization is effective for one year from the date on which it was signed.

Prohibition on Conditioning of Authorization: I understand my physician will not condition treatment on my signing this authorization, unless I am receiving research-related treatment or the only reason the clinic is providing me with health care is to make a report to a third party, such as my employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law. Federal law (42 C.F.R. Part 2) prohibits redisclosure of records from federally-assisted substance abuse program without express written consent of the patient.

Revocation: I understand that I may revoke this authorization at any time by notifying my physician in writing by sending a letter or a completed Revocation of Authorization form to the manager of the clinic at which I receive health care. I understand that if I revoke this authorization, it will not affect any actions that my physician took before my revocation letter was received. For example, my physician cannot rescind disclosures that have already been made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in my physician's Notice of Privacy Practices. A fax or photo copy of this authorization shall be considered valid as the original

_____ _____

Signature of patient or personal representative *Date*

Printed name & relationship of personal representative, if applicable:

_____