AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: _____ (Facility Name)

_____ (Facility Address)

To Release To: _____ (Recipient Name)

_____ (Street Address)

_____ (City, State, Zip)

Telephone Number_____ Fax No._____

The following information from the medical record of:

Patient Name: _____ Date of Birth:_____

Date(s) of Treatment _____ Social Security No._____

Information to be released:

☐ Progress Notes ☐ History & Physical ☐ Operative Record ☐ Pathology Report
☐ Laboratory Reports ☐ Consultation Reports ☐ EKG/ECHO ☐ Itemized Bill
☐ Other (specify):_____

The information specified above is to be released for the following purpose:

☐ Treatment/Consultation ☐ Patient Request ☐ Billing or Claims ☐ Attorney
☐ Social Security Disability
☐ Other (specify) _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above facility. This authorization will automatically expire 180 days from the date of my signature unless revoked prior to that time or unless otherwise specified as follows _____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative

I understand that my treatment cannot be conditioned on whether I sign this authorization form. I authorize to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

_____ _____

Signature of Patient or Legal Representative **Date**

Authority to sign if not Patient _____