

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ who resides at _____
in the city of _____ in the state of _____ hereby authorize:

Name: _____
(PHYSICIAN, HOSPITAL, CLINIC, LAB, RADIOLOGY CENTER OR OTHER HEALTHCARE PROVIDER)

Address: _____

City, St., Zip: _____

to disclose the following specific medical information by mail or fax or e-mail to:

Name: _____

Address: _____

City, St., Zip: _____

from the Health Records of:

Name: _____
(NAME OF INDIVIDUAL WHOSE HEALTH RECORD IS BEING DISCLOSED)

Address: _____

City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

- _____ Statements of charges or payments
- _____ Records of visits (all visits)
- _____ Record of visit for a specific date or dates Specific dates include or are limited to: _____
- _____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)
- _____ Progress Notes
- _____ Photographs, videotapes, digital or other images
- _____ Discharge Summary
- _____ History and Physical Examination
- _____ Consultation Reports
- _____ All of the above
- _____ Other (Must be specific) _____
- _____ Mental Health and/or alcohol and drug abuse treatment
- _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
- _____ Hepatitis Information

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, _____ creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

WITNESS (Optional)

DATE