

Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, _____ may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning this form to this office.

AUTHORIZATION FOR THE RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient Name: _____ Date of Birth:

DD	MM	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below, I understand that once this information is disclosed, it may no longer be protected by _____. I understand that this authorization is voluntary, that further treatment can not be conditioned upon signing this authorization and that there may be a cost to copy records.

INFORMATION TO BE RELEASED (check all that apply) Date range (month/year): From:

MM	YYYY
<input type="text"/>	<input type="text"/>

 To:

MM	YYYY
<input type="text"/>	<input type="text"/>

- | | | |
|--|--|--|
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Mental Health Treatment | <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Clinic/Progress Notes | <input type="checkbox"/> Other Test Results |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other _____ | |

INFORMATION IS TO BE USED FOR:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Continuity of Medical Care | <input type="checkbox"/> Damage/Claim Information | <input type="checkbox"/> Personal |
|---|---|-----------------------------------|
- Other: _____

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 190 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

Signature of Patient or Authorized Representative _____ Date of Signature

DD	MM	YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Printed Name _____ Relationship to Patient (if applicable) _____

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I the patient/authorized representative have inspected and/or received photocopies of the medical records from _____ for the above named patient.

Date	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>DD</td><td>MM</td><td>YYYY</td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table>	DD	MM	YYYY	<input type="text"/>	<input type="text"/>	<input type="text"/>	Signature _____
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DD	MM	YYYY						
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