AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **Social Security #:** _____

Date of Birth: _____

Physician/Organization authorized to DISCLOSE information:

_____

Person/Physician/Organization authorized to RECEIVE the information (including address):

_____

_____

_____

Date(s) of service/care for information requested: _____

Information to be disclosed (include dates where appropriate):

☐ Problem List _____ ☐ Laboratory Reports _____

☐ Progress Notes _____ ☐ X-Rays/EKGs _____

☐ Entire Record _____

☐ Other (specify) _____

Purpose of this disclosure:

☐ Continuation of medical care ☐ Attorney ☐ Marketing

☐ Substantiation of payment claims ☐ Personal use

☐ Other (specify) _____

Information should be delivered via (select one):

☐ I will inspect and review the record on-site ☐ Mail to address above

☐ Fax to _____

☐ Pick up (provide name of individual picking up information) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.
2. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, for Ohio entities this authorization will expire in 60 days; for Michigan entities this authorization will expire in 6 months. If this authorization is for a use or disclosure of PHI for research, this authorization will expire at the end of the research study.
6. Our practice is no longer responsible for what happens with PHI once it is disclosed to the person or entity the patient authorized to receive such information.

Signature of Patient or Legally Authorized Representative: _____ **Date:** _____

Relationship to Patient: _____ **Witness:** _____

If you are the legally authorized representative of the patient, describe the scope of your authority (attach proof):

☐ Parent ☐ Durable Power of Attorney for Health Care

☐ Legally Authorized Representative ☐ Personal Representative of the Estate