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PERMISSION TO RELEASE MEDICAL RECORDS AND/OR AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

PATIENT NAME: _____ DOB: _____

CURRENT ADDRESS: _____

CELLPHONE: _____ ALTERNATE PHONE: _____

PURPOSE OF REQUEST:

- ☐ CHANGE DOCTORS
- ☐ DOCTOR CONSULTATION
- ☐ MOVING/RELOCATING
- ☐ LEGAL REASONS
- ☐ SELF USE (PATIENT/REPRESENTATIVE WILL BE CHARGED A FEE)
- ☐ CONTINUITY OF CARE
- ☐ TELEPHONE COMMUNICATION
- ☐ OTHERS

INFORMATION TO BE DISCLOSED – General Medical Information:

Describe the type of protected health information (PHI) you are authorizing to be used and/or disclosed:

- ☐ Physician notes and medical records
- ☐ Imaging (x-rays, MRI, CT Scan, etc.)
- ☐ Lab Reports
- ☐ Immunization history
- ☐ School: general/special educational and/or discipline records, testing/evaluation results, counseling information

I AUTHORIZE INFORMATION TO BE RELEASED FROM:

NAME OF FACILITY: _____

NAME OF DOCTOR: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

I AUTHORIZE INFORMATION TO BE RELEASED TO:

NAME OF FACILITY: _____

NAME OF DOCTOR: _____

ADDRESS: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

EXPIRATION OF RELEASE/AUTHORIZATION

This authorization is valid for 90 days or until (specific date) _____ and may be revoked by the patient or representative orally or in writing at any time by contacting our HIPPA Privacy Officer. However, I understand that I may not revoke this authorization for any actions that have already occurred as instructed in this consent.

I understand that, by signing this form, I am confirming my release/authorization for use and/or disclosure of HPI described in this form with the people and/or organizations named in this form. It may re-disclosed by the recipient without the knowledge or consent of our clinic or you. This information may not be protected by Federal privacy regulation. I give authorization to fax my medical information. I understand the risk involved in faxing records and confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

ADDITIONAL PROTECTED MATERIAL: Your general medical information may contain references to your mental state, drug and alcohol conditions, or HIV status or sexually transmitted diseases. You consent to allow the above mentioned facility to release documents that may contain such information in my general medical record at this time.

1. Mental State and/or Behavioral Health Issues: I specifically consent to disclose such records as they require a separate authorization for complete release.

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

2. Drug and Alcohol Conditions: I specifically consent to disclose such records as they require a separate authorization for complete release.

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

3. Sexually Transmitted Disease and HIV/AIDS: I specifically consent to disclose such records as they require a separate authorization for complete release.

_____

SIGNATURE OF PATIENT (OR LEGALLY RESPONSIBLE PERSON)

DATE: _____

WITNESS: _____ DATE: _____