Authorization for Use and Disclosure of Protected Health Information

PATIENT IDENTIFICATION:

Name: ____

Date of Birth: ______________________________________

Address: ____

____

SS #: _________________Telephone:________________

PURPOSE OF REQUEST:

_____Treatment or Consultation

_____ Transfer of care

_____ Other: _______________________________

PLEASE DON'T SEND RECORDS IN DISK FORM

PERSON AUTHORIZED TO RECEIVE THE RECORDS:

Name: ____

Address: ____

____

Telephone: _______________Fax: _________________

PERSON AUTHORIZED TO RELEASE THE RECORDS:

Name: ____

Address: ____

____

Telephone: __________________Fax: _______________

INITIAL TYPE OF INFORMATION TO BE RELEASED:

_____Emergency room report _____Laboratory test report _____Radiology imaging Report
_____Operative report _____History & Physical exam _____ Itemized billing
_____Discharge Summary _____Consultation report

Other: ____

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 Sherwood Family Medicine. Unless revoked, this authorization will expire in 180 days or on the following date or event: ____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release
I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release.
Initial YES_______ Initial NO_______

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. **Initial YES_______ Initial NO_______**

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 Insurance 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 Who May Request Disclosure
I understand that Sherwood Family Medicine may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.
I authorize Sherwood Family Medicine to use and disclose the protected health information specified above.

Signature: ____Date: ____________________________

Relationship if not patient: ____

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