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Authorization for Use and Disclosure of Protected Health Record Information

Physician Name _____ Fax _____

Is authorized to release the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> EKG/ECHO | <input type="checkbox"/> Emergency Room Records |
| <input type="checkbox"/> Shot Records | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-Ray Reports/Films | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Senior Health Records | <input type="checkbox"/> Basics/Abstract | <input type="checkbox"/> Psychiatric Records | |
| <input type="checkbox"/> Complete Record | <input type="checkbox"/> Itemized Bill | | |
| <input type="checkbox"/> Other: Please specify: _____ | | | |

The information that is to be released from my medical records is for the following purpose:

- | | | | |
|---|--|-----------------------------------|--|
| <input type="checkbox"/> Continued Medical Care | <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Attorney | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Patient Request | | | |
| <input type="checkbox"/> Other: _____ | | | |

To _____ Phone _____ Fax _____

Releasing information about drug abuse, alcohol abuse, psychiatric care, and or HIV/AIDS

I understand that even if my medical or billing records contain information that reference my drug abuse, alcohol abuse, psychiatric care, sexually transmitted disease history, Hepatitis B or C testing, and/or other sensitive information, I still agree to its release

Please check one: _____ Yes _____ No _____ Initials

I understand that is my medical or billing record contain information that refers to HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/ or treatment, I still agree to its release.

Please check one: _____ Yes _____ No _____ Initials

Time limit and 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 Doctors of Internal Medicine.

Re- disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA- Act of 1996). Doctors of Internal Medicine and its employees are hereby released from any form of legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of patient or personal representative

I understand that Doctors of Internal Medicine may not condition my treatment on whether or not I sign this authorization form. I authorize Doctors of Internal Medicine to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for copies.

Signature of patient or legal representative

Date

Printed Name (Or representative)

DOB