**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

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| --- |
| **A close up of a sign  Description automatically generated** |

|  |  |
| --- | --- |
| NAME OF PATIENT |  |
| DATE OF BIRTH |  | SS# |  |

|  |
| --- |
| RECORDS WILL BE DISCLOSED TO: |
| Name |  | Phone |  |
| Address |  | Fax |  |

**For the Following Purposes**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Continuity of Care |  | Personal Information  |  | Legal (To Attorney/Court)  |
|  | Disability Insurance |  | Other: |  |

**By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:**

|  |  |
| --- | --- |
|  | **Please send the entire Medical Record (all information) to the above named recipient.** |
|  | Office Notes and Reports |  | Diagnostic Reports |  | Billing Statements |
|  | Rx History |  | Transcribed Hospital Reports |  | Laboratory Reports |
|  | Others Listed Here: |
|  |  |
|  | **Time Period Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:**

\_\_\_\_\_\_\_ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

\_\_\_\_\_\_\_ Mental Health Information and/or Records

\_\_\_\_\_\_\_ Domestic Violence

\_\_\_\_\_\_\_ Genetic Testing Information and/or records

\_\_\_\_\_\_\_ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand** that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

**I also understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

**I, further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

**Finally, I understand** that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing

or until (Insert Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **We use a flat fee or actual costs based on type and amount of records for records requests with a signed consent from the patient:**

|  |  |
| --- | --- |
|  [ ]  CD of Electronic Records:  | Flat Fee of $6.50 |
|  [ ]  Paper Records Copied under 100 pages:  | Flat Fee of $6.50 |
|  [ ]  Paper Records Copied over 100 pages:  | $.08 per page + labor at $.24 per min. and postage |
|  [ ]  Emailing of Records:  | Flat Fee of $6.50 |
|  [ ]  Thumb Drive:  | Cost of thumb drive, labor at $.24 per min. and postage (*We can only use storage devices provided by our office*) |

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***I give authorization to the provider listed above to disclose a copy of the specific health/medical information identified above:***

Print Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient’s Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Personal Representative (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identity of Requestor Verified:** [ ]  Photo ID [ ]  Matching ID [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_