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All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name | Date of Birth | Account #

Address | Telephone No.

I authorize the use and disclosure of health information about me as described below:

Practice Authorized to Release my Health Information | Telephone No./Fax

Address

Agency or Individual(s) Authorized to Receive my Health Information

Health information that may be used / disclosed is limited to the following:

☐ Encounter Form ☐ History & Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Physician Note ☐ Imaging/X-ray ☐ Entire Record ☐ Other (specity)_____

Health information that may be used/disclosed is limited to the following treatment dates:_____

Health information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s):

☐ Treatment/consultat ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ other_____

"Health Information" Identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hearby discharge the releasing practice, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** complied during my visit or encounter, or make copies thereof in accordance with the policies of this practice.

Protected Health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipent and is no longer protected by this privacy rule. If research-related Health information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will autorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of specific event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the practice has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the health information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Account-ability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature | Date | Time

Relationship to Patient/Authority to Act on Patient's Behalf | Interpreted, If utilized

Witness's Signature | Expiration Date or Event

*Signature must be validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records

Authorization to Use and Disclose
Protected Health Information

Patient Label