AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____ hereby authorize
(**Person Signing Authorization**)
_____ to furnish the following medical information to
(Healthcare Provider name and Address)

_____
(**Name, Address, and Phone of Receiving Party**)

Purpose of disclosure: ☐ Request of individual ☐ Other _____

** Individual requests may take up to 72 hours to process to give us time to prepare your records and may include a fee.**

Patient Name: _____ Date of Birth:____/_____/_____

Specific Information to be Released: Date of Treatment: _____

- ☐ Lab Report
- ☐ Pathology Report
- ☐ Imaging Report
- ☐ EKG
- ☐ Immunization Record
- ☐ Physical
- ☐ Office Visit Note
- ☐ Other_____

Request Format: ☐ Paper ☐ Electronic Method of Retrieval: ☐ Mail ☐ Pick-up

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months or _____.
(Date)

I understand that the information (excluding mental health information) that is being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer be protected under the Heath Insurance Portability and Accountability Act.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I agree that a photocopy of this authorization is as valid as the original.

Signed _____ Date: _____
(Patient/Representative)

If signed by other than the patient, please indicate relationship and why patient did not sign: _____

_____

Witness: _____ Date: _____
(SIH Medical Group Employee)