Authorization for Use and Disclosure of Protected Health Information

PATIENT IDENTIFICATION
Name ______________________ DOB ________
Address _________________________________
____
Social Security ___________ Ph# ____________

DATES OF HEALTH CARE RELEASED
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____
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I authorized Dr. Caroline Peterson to acquire the following information from the following entity.

ENTITY AUTHORIZED TO RELEASE INFORMATION
Name ____________________________________
Address___________________________________
____
Telephone _________________ Fax _____________

PURPOSE OF REQUEST
- ◻Treatment or consultation
- ◻Request of Patient
- ◻Billing or claims payment
- ◻Other _______________

TYPE OF INFORMATION TO BE RELEASED
- ◻Emergency Room Report
- ◻Operative Report
- ◻Discharge Summary
- ◻History & Exam
- ◻Imaging ____
- ◻Imaging Report __________________________________
- ◻Lab ____
- ◻Consultation
- ◻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 Caroline Peterson privacy officer. 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 drugs and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatisit 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 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 not longer be protected by thte Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians aare hereby released from any legal responsibility or liability for disclosure of the above information to the extend indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure I understand that Caroline Peterson 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 __________________________ to use and disclose the protected health information specified above.

Signature ____ Date ______________

Printed Name ____
Relationship if not the patient ____

PLEASE MAIL OR FAX INFORMATION TO
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