

Please select your Provider
Teresa Craddock _____ Dawne Lowden _____
Janey Maki _____ Melissa Hague _____
Kelli Wehling _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name Previous Name

Date of Birth Address and Phone Number

- 1. I authorize the use or disclosure of the above named individual's health information as described below.
- 2. The following individual or organization is authorized to make the disclosure:

Name of organization or individual information is going to.

- 3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- Entire Record
- Most recent history and physical
- Most recent discharge summary
- Lab Results From (date)_____ to _____(date)
- X-Ray and Imaging Reports From (date)_____ to _____(date)
- Consultation Reports From (date)_____ to _____(date)
- Other_____

- 4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also

- 5. This Information may be disclosed to and used by the following individual or organization:

Address Phone Number Fax Number
For the purpose of:_____

- 6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so IN WRITING and present my written revocation to the address below. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

ATTENTION MEDICAL RECORDS

- 7. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

I understand and agree to pay for the cost of copying the requested records.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.
I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
If I have questions about disclosure of my health information, I can contact the clinic's privacy officer.

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Relationship to Patient Witness

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