**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION**

**I hereby authorize** **\_\_\_\_\_GENERATIONS FAMILY MEDICINE AND OB \_**

To release Information from the medical records for:

**Patient’s Name (please print) Date of Birth**

To:\_ (F) (P)

This Information for which I am authorizing disclosure will be used for the following purpose:

□ My personal records

□ Sharing with other health care providers as needed

□ Other (please describe)  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Type of Information Requested:** | X | Lab Results – specify date(s) or type of labs to be disclosed |
| X | Discharge Summary |  |  |
|  | X-ray Report | X | Consultation Reports from Dr. |
| X | Immunization Records |  |  |
| X | History and Physical |  | Entire Record |
|  | EKG |  |  |
|  | Psychiatry Records |  | Other (please describe) |
|  |  |  |  |

I understand that the records released may contain the following information which is protected by state and/or federal law and I authorize you to release this information (**you must initial all those that apply**):

\_\_\_\_\_\_ \***Mental Health Treatment**

\_\_\_\_\_\_ \***Drug and Alcohol Abuse**

\_\_\_\_\_\_ \***AIDS/HIV related information**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I much do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. Unless I specify differently, this authorization will expire (insert date or event) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify and expiration date or event, this authorization will expire in six months from the date on which it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations. 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 acknowledge that I may be charged a reasonable, cost-based fee for making copies. State law allows.