McKenzie Family Practice

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize to release a copy of health information described below regarding:

_____, _____,_____ _____
Print Name DOB Phone Number (other names used)

from _____,
Dr. Name, Address, Phone Number

to _____.
Dr Name, Address, Phone Number

The health information to be released includes information specifically authorized below as well as my health records for the last 2 years, including clinical notes, lab reports, the past 5 years of x-rays, diagnostic test and operative reports.

Purpose of release: Personal request_____ Transfer of Care_____ Coordination of care _____ Other _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
____ By initialing here, I specifically consent to the disclosure of my mental health information.
____ By initialing here, I specifically consent to the disclosure of my genetic testing information.
____ By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed:_____.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ Date:_____
(print patient's name)

_____ _____
(signature of patient or Authorized Representative) Relationship

A copy of signature shall be considered as original

If we, the health care provider, are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

(1) *We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
(2) *You may inspect a copy of the protected health information to be used or disclosed;
(3) *You may refuse to sign this Authorization; and
(4) *We must provide you with a copy of the signed authorization.

This authorization will expire in 60 days and can be revoked in writing at any time except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this authorization, please contact our Privacy Officer.

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