

Holy Family Medical Associates, LLC

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name _____ Date of Birth _____ Phone _____
(Please Print)

Address _____

THIS WILL AUTHORIZE: _____ (name of person or organization)
_____ (address/phone/fax)

TO RELEASE INFORMATION TO: _____ (name of person or organization)
_____ (address/phone/fax)

PURPOSE OF DISCLOSURE ___ Transfer of care ___ Personal Record ___ FMLA* ___ Disability* ___ Other _____

INFORMATION TO BE DISCLOSED:

___ Complete/Record or

___ History & physical exam ___ Emergency Room record ___ Office/Clinic notes ___ Lab reports
___ Discharge report ___ Radiology Reports ___ After care plan ___ Billing record
___ Progress Notes ___ Consultation Report ___ Immunization record

I specifically authorize the release of information relating to:

- ___ Substance Abuse (including drug/alcohol abuse)
___ Mental Health
___ HIV/AIDS related information (including test results)

Date(s) of Service _____
(State specific dates, time period or "All")

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at the organization.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.
3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to the organization. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) this document and this disclosure is at my request.
5. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

Signature of patient or patient's personal representative

Date

Relationship to patient if signed by personal representative

*Note: Once the office disclose health information, the person or organization that receives it may be able to disclose it. Privacy laws may no longer protect it.