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)

IF SENDING MORE THAN 40 PAGES. PLEASE SEND (address/phone/fax) CD OR USB - DO NOT FAX

_____ (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.

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