Authorization to Release and/or Obtain Health Information

Patient Full Name:_____

Date of Birth:_____

*Check all that apply

___ I hereby authorize Dr. MA to release my medical information **to** _____.

___ I hereby authorize Dr. MA to obtain medical information **from**_____.

Address of Individual or
Facility:_____
Telephone of Individual or Facility:_____
Fax:_____

Information to be Released/Obtained may include:

History and Physical Progress Notes Consultations
Discharge Summary Operative Reports EKG Report
Laboratory Reports Radiology Reports Outpatient Clinic Records
Emergency Medicine Report Other Diagnostic Reports
Immunizations/Vaccinations

Specific Authorizations: Check all that apply:

___ I authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.

___ I authorize the release of information pertaining to mental health diagnosis or treatment.

___ I authorize the release of HIV/AIDS testing information

Purpose of Release/Obtaining Medical Information: Check all that apply:

___ Coordination of Care ___ Continuity of Care

___ Billing and payment ___ At request of client or client representative

___ Other:

Effective Date of Authorization:_____

Duration of Authorization:_____

Please Note: Dr. CI MA, like many other health organizations, physicians, hospitals, and health plans, is required by state and federal law to keep your health information confidential. For full details of Dr. CI MA's privacy policies, please refer to the Notice of Privacy Practices. If you do authorize disclosure of your protected health information to an individual or organization who

is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

My Rights

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a clam, or 4) to create health information to provide to a third party.
Under no circumstances am I required to authorize the release of mental health records.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. CI MA and/or the healthcare professional or facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- I am entitled to receive a copy of this Authorization.

Signature _____

Date:_____

Signature of Client or Client's Legal Representative