Authorization for Disclosure of Protected Health information

ima | Healthcare
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Instructions: Fill out each section of the form in its entirety. You may mail, fax, email or hand deliver this release when completed to the address or fax listed. Failure to do so may delay in processing of your request.

Patient Name: _____ Date of Birth: _____

Full Address: _____

Phone Number: _____

Maiden/Previous Names: _____

Release of Information From:

Name/Facility: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Release of Information To:

Name/Facility: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Purpose of Release:

- ☐ Continuing Medical Care
- ☐ Insurance Claim
- ☐ Application for Insurance
- ☐ Other: _____
- ☐ Worker's Comp
- ☐ Disability Determination
- ☐ Personal

If you have a preferred provider you would like to see at our clinic, please list: _____

Information to be Released: Service Dates from: _____ To: _____ **or** ☐ all future records

- ☐ Complete Medical Record
- ☐ History & Physical
- ☐ Procedure Reports
- ☐ Imaging Reports/ Images
- ☐ Admit/Discharge Summaries
- ☐ ER Reports
- ☐ Alcohol/Drug Treatment Records
- ☐ Lab/Pathology Reports
- ☐ Psychological Eval/Assmts
- ☐ EKG & Cardiology Reports
- ☐ Medications
- ☐ Consultations
- ☐ Immunizations
- ☐ Final Diagnosis
- ☐ Other (specify): _____

NOTE: This authorization expires form one year from the date of my signature unless I specify a different event, purpose, or alternative, expiration date here: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SEPCIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release of Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature (required): _____ Date Signed (required): _____

Printed Name of Person Signing (if not patient): _____