AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Equine Connections, LLC

www.equineconnectionsaz.com

Patient Information		
Patient Name:	Gender:	DOB:
Patient Address:		

AUTHORIZATION			
Equine Connections, LLC PO Box 7203 Chandler, AZ 85246 equineconnectionsaz@gmail.com (480) 785-6991			
I authorize the release and disclosure of my protected health information between Barn Yard Equine and the following:			
( ) Medical Facility	( ) Person	( ) Legal Entity	( ) Other: ______________________
Facility:			
Name:		Relationship:	
Address:			
Email:		Phone:	

INFORMATION RELEASED INCLUDES:			
( ) All Medical records	( ) Transfer of Care	( ) Medication List	( ) Hospital Records
( ) Lab Results	( ) Imaging Results	( ) Test Results	( ) Discharge Summary
( ) Verbal/Written Communications		( ) Other: ____	

REASON FOR INFORMATION	
( ) Coordination/Continuity of Care ( ) Transfer of Care ( ) Insurance ( ) Legal ( ) Personal ( ) Other: ____	
Dates Needed: ONE YEAR	If Other Dates Needed, Specify:

1. I understand that my Protected Health Information may contain information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care, Psychiatric Care, treatment of alcohol/drug abuse and genetic testing.
2. I understand that my treatment from Equine Connections, LLC is not contingent on my signing this authorization. The facility will not deny me treatment if I do not wish to sign.
3. I understand that the information released may no longer be protected by state and federal regulations and may be redisclosed by the authorized recipient.
4. I understand I may revoke this authorization at any time by simply submitting a written request to Barn Yard Equine.
5. I understand this AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED, if not revoked prior to expiration date.
6. I release Equine Connections, all providers and staff, from any legal liability for the release of information in accordance to the above authorization.

By signing this form, I, the patient, authorize release of my protected health information, including a copy of my medical records, and/or a summary or narrative of my protected health information, TO and FROM Equine Connections, LLC and the entity authorized above.

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PATIENT Signature Date

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GUARDIAN Name (if applicable) GUARDIAN Signature Relationship