SILVER BIRCH
– MEDICAL CLINIC –

Authorization for Disclosure of Health Information
(HIPAA Release)

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Phone: _____ Last 4 SSN: _____

I authorize the use or disclosure of the above-named individual's health information by previous and current healthcare providers, including but not limited to (ex. Dr. Bob – Mercy Dermatology Rogers, AR):

_____

_____

_____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records _____ Lab results/X-ray reports _____ Medical Exam
_____ Consultation reports _____ Immunization record
_____ Other (please specify): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization for the purpose of continuing care:

SILVER BIRCH MEDICAL CLINIC
4052 E. VAN BUREN, EUREKA SPRINGS, AR 72632
PHONE#: 479-379-8082 FAX#: 479-365-3492
EMAIL: reception@silverbirchmedicalclinic.com

I understand that I have a 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 the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 365 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive continued treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of participant or representative Date

_____
Print name of patient or representative