FANNO CREEK CLINIC, LLC.

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MEDICAL AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

~PLEASE PRINT~

I, (patient's name): _____ DOB: _____
authorize the disclosure of my health information as identified below:
FROM: [provider's name/ address]:
_____
_____
TO: [recipient's name/address]**:** _____
_____
for the following purpose (s) [**please initial]**: Change of provider _____ Continuity of care_____
"At the request of the patient"_____ or Other (describe initial):_____
_____.
By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and records:
_____ Entire medical record (all information)
_____ Billing record
_____ Medical records developed from _____ to _____ [start date/end date]
_____ **other [specify]: _____.
****If the information to be used or disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information may apply. I agree the following categories must be initialed to be included in this authorization to release information:
_____ ****HIV/AIDS related health information/records
_____ ****Mental health information/records
_____ ****Genetic testing information/records
_____ ****Drug/alcohol diagnosis, treatment and/or referral information. [Federal law prohibits the re-disclosure of this health information.] Federal law requires that a description of the kind of information and how much, be included in this request: _____.
_____ *****Psychotherapy notes [If authorization is for the disclosure of psychotherapy notes, it cannot be combined with any other authorization.]

*****REQUIRED:** Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. **Unless revoked earlier, *this authorization will terminate on]*: ***_____***.**

I understand I may inspect or copy any information disclosed under this authorization unless otherwise restricted by law.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I understand that the person{s} I am authorizing to use or disclose my information may receive compensation for doing so.

_____ _____
(Signature of Individual or legal Representative) (Date)

_____
(Relationship to Individual)

[A copy of this signed form will be provided to the individual and/or the individual's legal representative]