Zabel Plastic & Reconstructive Surgery

Date:_____

Patient's Full Name: _____ Date of Birth:_____

Address:_____

City:_____ State _____Zip_____

Phone: ( )_____

I HEREBY AUTHORIZE THE FOLLOWING RELEASE OF MY HEALTH INFORMATION:

Receive Record From:

Clinic/Provider:

_____

Address:

_____

City State Zip

_____

Phone# Fax#

_____

Email Address:

_____

Send Records to:

Clinic/Provider:

_____

Address:

_____

City State Zip:

_____

Phone# Fax#:

_____

Email Address:

_____

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:

___ **Entire medical record~ all Examinations**

Or check the appropriate record:

___Discharge Summary

___Laboratory Tests

___Photographs, (if available)

___Video, digital or other images

___ History and Physic

___Ultrasound Reports

___ Progress Notes

___Consultation Reports

___ Health care information related to the following treatment, condition, or dates of treatment:_____

Zabel Plastic & Reconstructive Surgery

1. 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 mental health services, and treatment for alcohol and drug abuse. _____(Patients Initials)

2. I understand that I have the right to revoke this authorization at any time by presenting my written revocation to Zabel Plastic and Reconstructive Surgery at the below address. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy. If this Authorization has not been revoked, it will terminate on the following date, event, or condition: _____ If I fail to specify a date, event, or condition, this authorization will expire in 6 (six) months._____(Patients Initials)

3. I understand that I can refuse to sign this authorization. I need not sign this form to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules. If I have questions about users or disclosures of my health information, I can contact Zabel Plastic & Reconstructive Surgery at the above address._____(Patients Initials)

4. I understand that I may inspect a copy of the Protected Health Information to be used or disclosed and will receive a copy of this form once signed._____(Patients Initials)

5. I understand I will be charged a fee for faxing or photocopying and mailing my records. (Copying fee of $25.00 will need to be paid at the time of pickup/sending)_____(Patients Initials)

6. I understand that if the records are to be mailed an additional charge may be added. _____(Patients Initials)

Signature of Patient or Legal Representative

_____ DATE:_____

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