Reference Number:

Authorization for 3rd Party Disclosures

Dominion Records Retrieval & Management, LLC
PO Box 775 sbufkin@dominionrecordsrm.com
Tullahoma, TN 37388 P: 931-588-0504 Fax: 1-866-366-4874

AUTHORIZATION FOR 3RD PARTY DISCLOSURES

Form: DRRM 1-2

PATIENT NAME: ____________________

MRN: ____________________

LAST 4 DIGITS OF SSN: ____________________

DOB: ____________________

I authorize the use or disclosure of health information about me as described below.

1. Name and Address of Individual or Organization authorized to disclose the information:

____

2. Name and Address of Individual or Organization authorized to receive the information:

____

If you would like your records to be sent to a third party, please provide an address or fax where you would like us to send the information (e.g., Lawyer/Law Office, Insurance Company, etc.).

Name: ____________________ Address: ____________________

City: ____________________ State: ____________ Zip: __________

Phone: ____________________ Fax: ____________________

3. Description of information that may be used or disclosed and date range **(e.g., all information related to a specific type of treatment)**:

____

The following must be separately initialed or checked by you if applicable to your authorization:

____ HIV/AIDS STATUS – HIV related information, which includes any information indicating that I have had an HIV-related test, or HIV infection, HIV-related illness or AIDS, or any information which would indicate that I have been potentially exposed to HIV.

____ Sexually transmitted diseases ____Sexual assault information

____ Mental health treatment records governed under state law (including mental health records relating to involuntary or voluntary mental health treatment). *Mental health records may include substance abuse information.*

____ Substance abuse (drug and alcohol) treatment records. *Substance abuse information may be part of mental health records.*

4. The information will be used or disclosed for the following purposes:
☐ Treatment ☐ Benefits ☐ Legal ☐ Employment ☐ Other (Please specify below)

____

5. This authorization expires____________________*[insert a date or describe an event or activity related to the patient or purpose of the authorization]*. If not completed, this authorization will expire two years from date signed.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment, enrollment, or my eligibility for benefits. I understand that I may revoke this authorization at any time by sending a written request to the Dominion Records Retrieval & Management, PO Box 775, Tullahoma, TN 37388, except to the extent that action has been taken in reliance on this authorization.

____________________ ____________________
Signature of Patient or Representative Date

____________________ ____________________
Patient Name Patient Address

____________________ __________ __________
Patient Contact Phone Number Last 4 Digits of SSN Date of Birth

____________________ ____________________
Name of Personal Representative (if applicable) Relationship to Patient