

Daniel Gaitan Personalized Healthcare

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ SSN: _____

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure (where information is coming from):

2. The following person or class of persons may receive disclosure of protected health information about me (where information is going):

Dr. Daniel Gaitan, MD, FACP, FACE
425 North New Ballas Road, Suite 107
St. Louis, MO 63141

3. The specific information that should be disclosed is: **ALL MEDICAL RECORDS**

4. I may revoke this authorization by notifying the office manager of Daniel Gaitan Healthcare in writing of my desire to revoke it. I understand that any action taken already in reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

5. I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal privacy regulations.

6. This authorization expires on _____ or upon the event that relates to the purpose of the intended use of this authorization for disclosure of information.

7. I understand that the mentioned medical record may include Alcohol /Drug Abuse, Psychiatric treatment records, or HIV / AIDS testing and treatment and are covered by Federal Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

8. Daniel Gaitan Healthcare, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

Signature of Patient

Date

Signature of Guardian/Representative /Relationship

Date