Release of Medical Information Form

****Authorization for Use or Disclosure of Protected Health Information**

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Authorization

I (individual/patient) _____authorize _____

disclose and release my protected health information to_____.

Effective Period

This authorization for release of information covers the period of healthcare from:

_____ to _____

Extent of Authorization

a) I authorize the release of my complete health record ☐

or

b) I authorize the release of my complete health record with the exception of the following information: ☐

_____

I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by federal regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, such information will be included in this disclosure.

By signing below:

• I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to **Rhema Healthcare Services.**

• I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the **Rhema Healthcare Services** from all legal responsibilities and liabilities that may arise from the release of such protected health information.

• I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

Signature:_____ Relationship:_____ Date:_____

** If signed by a legal representative (1) Print your name:_____