FRIEDEL CLINIC

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____
_____
_____
_____

RE: Patient's Name: _____

Date of birth: _____ SSN#: _____

I authorize and request disclosure of all protected information for the purpose of review and evaluation in connection with therapy/treatment. I expressly request that the designated record custodian of all covered entities under HIPAA, identified above, disclose full and complete protected medical information, including the following:
All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurses' notes, social worker records, clinical records, treatment plans, admission records, discharge summaries, requests for, and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories.

- All physical, occupational, and rehab requests, consultations, and progress notes.

- All laboratory, histology, anthology, records, and specimens; radiology records and

Films, including CT, PET, SPECT, MRI, fMRI, MRA, EEG, and qEEG scans. Videos/CDs/reports.

- All pharmacy/prescription records, including NDC numbers and drug information.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release for disclosure of this type of information.
This authorization is given in compliance with federal consent requirements for the release of alcohol and substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
You are authorized to release the above records to the administrative representative in

charge of records at Friedel Clinic by way of transfer, the most convenient method that best protects the confidentiality of these records.

I understand the following: (CFR § 164.508 C 2 i-iii)
I have the right to revoke this authorization in writing at any time, except to the extent Information has been released in reliance upon the authorization.
The information released in response to this authorization may be disclosed to other parties.

My treatment or payment of my treatment cannot be conditioned on the signing of this authorization.

Any facsimile of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution when this authorization expires.

_____ _____
Signature of patient or legally authorized representative Date

_____
Name and relationship of the legally authorized representative to the patient

_____ _____
Witness signature Date