AUTHORIZATION TO OBTAIN & DISCLOSE MEDICAL INFORMATION

Patient Information

Name (Last, First, MI)____

Address____

Alias/Other names______________________________ Date of Birth________________________

Please OBTAIN information FROM the following:

____
Name of health care provider

____
Address

____
City, State, Zip code

____
Phone/Fax

Please SEND my health information TO:

____
Name of health care provider

____
Address

____
City, State, Zip code

____
Phone/Fax

Information to be disclosed. (Please check only one box)

❒ Complete copy of official medical record (contains all discharge summaries, all outpatient notes, all pathology reports, and all clinic summaries, x-ray, EKG and lab reports)

❒ Most recent 2 years of complete record

❒ Records pertaining to the following date(s) or condition(s):______________________________

❒ Other:______________________________

If the information to be disclosed contains any of the types of special information below, additional laws relating to the use and disclosure of it apply. With my initials, I authorize disclosure of the following information:

_____ Mental health information
_____ Alcohol or drug treatment
_____ Developmental disabilities
_____ HIV/AIDS-related information &/or results

Duration: This authorization will begin immediately and remain in effect until (date)________________________ or not more than six months from the authorization date below.
Restrictions: I understand that if the person(s) and/or organization(s) authorized by this form to receive my medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release my medical information without my prior permission.
Rights: I understand that I am under no obligation to sign this form, and that my refusal to sign will not affect my ability to obtain treatment. I have the right to inspect or copy the medical information authorized here, with certain exceptions provided under state and federal law. I understand I have the right to revoke this authorization, in writing, at any time before it ends, and Salvia Medica has 30 days to comply with my written request. My written revocation will not affect any disclosures of my medical information that the person(s) and/or organization(s) have already made, in reliance on this authorization, before the time I revoke it.
Copying Fees: If I am requesting disclosure/release of medical information to other hospitals, clinics, or healthcare providers for further medical care, no copying fees will be charged. I must pay for copies I request for other purposes.

Signature: I have read this authorization, or had it read to me, and I understand it.

____
Patient or Personal Representative

____
Date

____
Description of personal representative's authority (relationship

____
Office use only – Records sent by

____
Date sent