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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name:_____DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____What Doctor Do You See (Circle): Dr Boyd Dr Franzen
Dr O'Connor Dr Schieber

PLEASE COMPLETE THE FOLLOWING INFORMATION IN ORDER TO PROCESS YOU REQUEST

I WOULD LIKE MY MEDICAL RECORDS OBTAINED FROM:

Physician /Clinic/Self _____

Address _____

City/State/Zip _____

Phone:_____ Fax:_____

ARE YOU TRANSFERRING CARE? YES_____ NO_____

_____ ALL LAB RESULTS **_____ HIV TEST RESULTS**

_____ LAST 2 YEARS **_____ DRUG AND/ OR ALCOHOL ASSESSMENT/TREATMENT**

_____ ALL MEDICAL RECORDS * (PHYSICIAN APPROVAL _____)*

_____ RECORDS CONFINED TO THE FOLLOWING CONDITION_____

_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Guardian Signature: _____ Date: _____

Please Note: **Medical records are completed in the order in which they are received. Please allow 10 days for the processing of your request. This request expires in 60 days. This information has been provided to you from confidential records protected by state law. You shall make no disclosure of this information without the specific written and informed consent of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purposes of release of HIV test results or diagnosis.*