Downtown Medical Group

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Authorization for Use of Disclosure of Protected Health Information

I, _____, date of birth ____/____/____, authorize _____
(Patient's Name) mm/dd/yy (Past Provider/Facility's name)

_____todisclose
(Past Provider/Facility's address, phone & fax number)

the protected health information described below to ***Downtown Medical Group and its physicians.***

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

a. ☐ Date_____ to Date_____.

OR

b. ☐ all past, present, and future periods.

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol and/or drug abuse). _____ (initial)

OR

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

- ☐ Mental health records _____ (initial)
- ☐ Communicable diseases (including HIV and AIDS) _____ (initial)
- ☐ Alcohol/drug abuse treatment _____ (initial)
- ☐ Other (please specify): _____. _____ (initial)

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force now and effect until the receipt of the requested information.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____

Patient Name (Printed) **Signature** **Date**