HAPPI Health

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Angelique Andrews, MD
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Authorization for Release of Confidential Information

Patient's Name:__________________DOB(Date of Birth):___________

I authorize _______________________________ to release my protected health information to 'HAPPI Health' for the purpose of continued care.

Description of records to be disclosed, including dates: All Records

- I understand that I may change my mind and revoke (take back) this Authorization at any time in writing, except to the extent that the persons authorized above, have already acted based upon this authorization.
- I understand that PHI disclosed based on this authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.
- I understand that PHI disclosed based on this authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that this authorization expires one year from the date of signature, or sooner as indicated by date I write in here____________.
- I acknowledge that HAPPI Health:____________will___________will not recieve payment or other remuneration from a third party in exchange for using or disclosing my proteted health information.

_______________________________ ______________________

Signature of Patient or Guardian Date of Authorization