PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name:________________________________ Birth date:_______________ Maiden/previous/other names: ____________________________
(Please print) (Please print)

THIS WILL AUTHORIZE:____(Name of person or organization)
____(Address)

TO RELEASE INFORMATION TO:____(Name of person or organization)
____(Address)

☐ Please mail ☐ Please fax ☐ Will pick up

INFORMATION REGARDING:

☐ **All medical records** ☐ Operative reports ☐ Mental health ☐ Audiology
☐ Ear, Nose, Throat ☐ Consultations ☐ History and physical ☐ Education (IEP)
☐ Neurologic ☐ Lab reports ☐ Physical form ☐ Treatment plan
☐ Ophthalmology ☐ Orthopedic ☐ X-ray reports ☐ Immunizations
☐ Allergies ☐ Other ____________________________

INFORMATION TO OMIT (CHECK ALL THAT APPLY):

☐ Mental health records ☐ HIV records ☐ Substance abuse (Alcohol/Drugs) records ☐ Other ____________________________

PURPOSE OF RELEASE (CHECK ALL THAT APPLY):

☐ Treatment/Referral ☐ Evaluation ☐ Insurance purposes ☐ Personal use ☐ Change of provider

IF YOU ARE CHANGING PROVIDERS, PLEASE MARK THE REASON (CHECK ALL THAT APPLY):

☐ Prefer different office location ☐ Age of children ☐ Provider not in your network
☐ Problems with office staff ☐ Inadequate appointment availability ☐ Moving out of town
☐ Prefer different physician ☐ Other (specify) ____

Cedar Plains Family Medicine (CPFM) will not receive payment or other remuneration from a third party in exchange for using or disclosing this information. You do not have to sign this authorization in order to receive treatment from CPFM. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time by providing a written request to the CPFM Privacy Officer, except to the extent that we have already acted in reliance upon this authorization.

I authorize the use and disclosure of the medical records and health care information indicated above (please print):

Signature:____ Print Name: ____
(Patient must sign if 19 years of age or over; otherwise parent, or legal representative)

Relationship to patient if not signed by patient: ____

Current address: ____
Street City State Zip

Current home phone: (_____)________________________Current work phone: (______)_____________________

Today's date: ________________ This authorization will expire on: ____
(specify an expiration date or event)

PLEASE NOTE: THERE WILL BE A $.50 PER PAGE CHARGE FOR COPYING RECORDS FOR PERSONAL USE ($50 MAXIMUM)

THERE IS NO CHARGE FOR RECORDS SENT DIRECTLY TO ANOTHER MEDICAL FACILITY.

(NOTE: The person signing this authorization is entitled to a copy of this form. If the information being released is for a patient who is 19 years of age or over at the time of the request, the patient must sign this form.)

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