DURHAM FAMILY MEDICINE

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize:

	Facility Name: _____ Address:_____ City: _____ State:_____ Zip:_____ Phone: (___) _____ Fax: (___) _____

to release/disclose to:

	Facility Name: _____ Address:_____ City: _____ State:_____ Zip:_____ Phone: (___) _____ Fax: (___) _____

the protected health information of:

Patient's Legal Name: _____

Address: _____ City: _____ State: _____

Telephone: ( ) _____ Date of Birth: / / _____ Zip: _____

(Required)

MR #: _____ Mother's Maiden Name: _____

Treatment Dates: _____

Information to be disclosed (please check (√) information requested)**:**

	Face Sheet			Discharge Summary			History and Physical
	Consultations			Physician Orders			Emergency Dept. Notes
	Medication/Graphic Sheets			Progress Notes			Operative/Procedure Notes
	Pathology Report			Pictures			Lab Reports
	X-Ray Reports/Films			Discharge Instructions			Nurses Notes
	Itemized Bills/Statements			Other:			

I acknowledge that the data released **MAY INCLUDE** material that is protected by law. My **initials** in the boxes below authorize the release (if applicable) of information pertaining to:

	Mental Health		Drugs & Alcohol		HIV / AIDS & other communicable diseases		Genetic Testing

The purpose of the use or disclosure is (please check (√) appropriate box)**:**

	Attorney/Legal		Continued Patient Care		Social Services / Disability
	Personal Use		Insurance		Other:

I understand that:

- I may revoke this Authorization at any time.
- The revocation will not apply to information that has already been released in response to this Authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.
- If I revoke this Authorization, I must do so in writing.
- The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department.

I also understand that:

- I may refuse to sign this Authorization.
- Durham Family Medicine will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for copying the protected health information.

Unless otherwise revoked, this authorization will expire automatically in ninety (90) days from the date of signature.

_____ _____
Signature of Patient Date

- OR -

_____ _____
Signature of Authorized Representative Date

_____ _____
Witness Date

Please explain the Representative's authority to act on behalf of the patient: _____
_____
_____

Date Completed: _____ Completed by: _____
Total Pages: _____ Sent via: ____ Mail ____ Fax ____ Picked-Up
Faxed to (number): _____ ❑ Fax # Verified ❑ I.D. Checked: