

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Generations Family Practice to disclose the following information from the medical records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Patient Number: _____

Covering the period(s) of health care:

From _____ to _____

From _____ to _____

Information to be disclosed:

Complete health record(s), including all images (x-rays, photographs, etc.)

Complete health record(s), excluding all images

OR

Select from the following (check as many as apply):

Discharge Summary

Progress Notes

History and Physical Examination

Laboratory Tests

Consultation Reports

X-ray reports

AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

Mental health care or services

Psychotherapy Notes

Treatment for alcohol and/or drug abuse

Photographs, videotapes, digital or other images

Other (please specify) _____

This information is to be disclosed to the following individual or entity for the purpose of:

Name: _____ Relationship: _____

Address: _____

Telephone: _____

The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of _____.

Initials: _____

b. I understand that I may revoke this authorization at any time by notifying Generations Family Practice in writing, but if I do it won't have any effect on any actions Generations Family Practice took before it received the revocation. Initials: _____

c. I understand that Generations Family Practice cannot make me sign this authorization as a condition to receive treatment from Generations Family Practice except:

(i) when Generations Family Practice provides me with research-related treatment; or

(ii) when Generations Family Practice provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Initials: _____

Generations Family Practice, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

Signature of Patient or Representative

Date

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****