



MaxHealth

Family, Internal & Sports Medicine

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient E-mail Address: _____

This form will authorize MaxHealth Family & Sports Medicine to provide a copy or summary of my medical records as indicated below:

Records to be released include: _____ Records for the period of _____ Through _____
 _____ Lab Results; Date(s) _____
 _____ X-Ray Copies; Date(s) _____ Type _____
 _____ Other: _____

<p>You must initial if you consent to the release of the following information in conjunction with the rest of your medical records:</p> <p>_____ AIDS or HIV Infection information</p> <p>_____ Drug, Alcohol or Substance Abuse</p> <p>_____ Genetic Information (including Genetic Test Results)</p> <p>_____ Mental health information</p>	<p>Reason for Release of information: <i>(Choose all that apply)</i></p> <p><input type="checkbox"/> Treatment/Continuing Medical Care</p> <p><input type="checkbox"/> Personal Use</p> <p><input type="checkbox"/> Billing or Claims</p> <p><input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> Legal Purposes</p> <p><input type="checkbox"/> Disability Determination</p> <p><input type="checkbox"/> School</p> <p><input type="checkbox"/> Employment</p> <p><input type="checkbox"/> Other (<i>Specify</i>): _____</p>
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The above information may be released to Persons/Organization(s):

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax#: _____

Expiration of authorization: (You must specify a date or event, i.e. at the end of litigation): _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed above and no longer protected. I have the right to revoke this authorization in writing except to the point that action has already been taken in reliance upon the authorization. I also understand that treatment or payment cannot be conditioned on the authorization.

Signature (Patient/Guardian): _____ Date: _____

REVOCATION SECTION:

I hereby revoke this authorization, effective ____/____/____.

Patient Signature

Date

Printed Name of Patient

Signature of Practice Privacy Officer

Date

If the Practice is seeking this authorization from you for a use or disclosure of your PHI, we will provide you with a copy of this signed authorization.