Toledo Bend FAMILY MEDICINE
A MEMBER OF THE PREFERRED FAMILY

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# AUTHORIZATION TO DISCLOSE and RECEIVE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Requesting records FROM: _____ PHONE (____) ____-_____FAX (____)____-_____

Sending records TO: _____ PHONE (____) ____-_____FAX (____)____-_____

For the purpose of: ( )Continuity of Care ( )Personal ( )Litigation ( )Other _____

Please release the following: ( ) Entire Record ( )Partial Record - Please Specify _____

_____Problem List _____All Imaging Reports- Date: _____ _____Progress Notes

_____History/Physical Exam _____Laboratory Results- Date: _____ _____Medication List

_____EKG Reports _____Immunization Record _____Genetic Testing Information

_____Other: _____

I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of the signature.

▪ Unless the purpose of this authorization is to determine payment of a claim or benefits, Toledo Bend Family Medicine may not condition the provision of treatment or payment for the care on my signing this authorization. ▪ Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

▪ THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICBLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS).

▪ The information authorized for release may include protected health information related to mental health.

▪ The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health.

Signature of Patient or Legal Representative _____ Date _____
Relationship to Patient (If Legal Representative) _____Witness _____

Employee Signature Releasing Records _____ Date _____