FAIRVIEW CLINIC, P.C.

Specializing in Internal Medicine

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Authorization to Use or Disclose Health Information

Patient Name ________________________________ DOB _______________ Chart No. _______

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organizations(s) are authorized to provide the records:

RECORDS FROM: ☐ ____

(enter name AND address of practice that currently has the medical records)

3. The type of information to be used or disclosed is as follows *(check appropriate boxes and include other information where indicated):*

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results *(please describe the dates/type of lab tests you want disclosed)*
- ☐ X-ray and imaging reports *(please describe the dates/type of lab tests you want disclosed)*
- ☐ Consult reports from ___________________________ *(enter doctor's name)*
- ☐ Entire record
- ☐ Other *(please describe: ____)*

4. This authorization allows ________________________ *(enter name of practice where records reside)* to release any and all medical records which may contain information concerning sexually transmitted diseases, drug and/or alcohol tests and treatment, psychiatric records and treatment, and tests or treatment for HIV/AIDS. ***Patient must read and initial here:***________

– continued on reverse –

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

RECORDS TO: ☐ ____

(enter name AND address of practice where records should be sent)

6. This information for which I'm authorizing disclosure will be used for the following purpose:

☐ my personal records
☐ sharing with other health care providers as needed
☐ transfer of records to another doctor; no longer a Fairview Clinic patient
☐ transfer of records TO FAIRVIEW CLINIC
☐ other *(please describe ____)*

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department of Fairview Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire *(insert date or event):* ______________________________
If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

____ ______________________________

Signature of ☐ patient ☐ legal representative Date *If legal rep, please enter relationship to patient*

____

Signature of witness Date

Original to chart – Copy to patient – Copy to accompany records used or disclosed