COMMUNITY CARE PHYSICIANS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name | **Patient's Date of Birth**

By signing this authorization, I authorize Community Care Physicians to use and/or disclose certain protected health information (PHI) about me to:

1. Please list other medical providers, family, friends, etc. who, with your permission, may receive your medical information. →

Person or Entity to Receive the Information

_____

_____

_____

2. Specific Information to be Released:

☐ Option 1: Entire medical record from (insert date) _____ to (insert date) _____ (If not specified, all dates.)
PLEASE NOTE: ***This includes any and all HIV-related information, drug and alcohol treatment, and mental health information. If you do not wish to have this information disclosed, please indicate below:***

Do NOT Include: ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

☐ Option 2: Include only:
☐ Prescriptions ☐ Office Notes ☐ Lab Results
☐ Billing ☐ Other (Please be specific): _____

Do NOT Include: ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

3. Please Initial:

_____ I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

4. The Reason for Release of Information: ☐ At request of individual ☐ Other: _____

5. Expiration Date: This authorization will expire on _____
{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____ _____

Print Name of Patient or Legal Guardian *Signature of Patient or Legal Guardian*

Date: _____ *Relationship to Patient*: _____