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Authorization for Use and Disclosure of Protected Health Record Information

Physician Name _____ Fax _____
Is authorized to release the following:

□ Discharge Summary □ History and Physical □ Operative Reports □ Pathology Report
□ Laboratory Reports □ Consultation Reports □ EKG/ECHO □ Emergency Room Records
□ Shot Records □ Progress notes □ X-Ray Reports/Films □ Occupational Health
□ Senior Health Records □ Basics/Abstract □ Psychiatric Records
□ Complete Record □ Itemized Bill
□ Other: Please specify: _____

The information that is to be released from my medical records is for the following purpose:

□ Continued Medical Care □ Billing or Claims □ Attorney □ Social Security
□ Patient Request
□ Other: _____

To _____ Phone _____ Fax _____

Releasing information about drug abuse, alcohol abuse, psychiatric care, and or HIV/AIDS

I understand that even if my medical or billing records contain information that reference my drug abuse, alcohol abuse, psychiatric care, sexually transmitted disease history, Hepatitis B or C testing, and/or other sensitive information, I still agree to its release.

Please check one: _____ Yes _____ No _____ Initials

I understand that is my medial or billing record contain information that refers to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I still agree to its release.

Please check one: _____ Yes _____ No _____Initials

Time limit and right to revoke authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Doctors of Internal Medicine.

Re-disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer by protected by the Health Information Portability and Accountability Act (HIPAA-Act of 1996). Doctors of Internal Medicine and its employees are hereby released from any form of legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Management of medical records

I understand that once Doctors of Internal Medicine has received and reviewed these medical records, the necessary records will be scanned into the patient's chart and the remaining medical records will be shredded as per HIPAA standards.

Signature of patient or personal representative

I understand that Doctors of Internal medicine may not condition my treatment on whether or not I sign this authorization form. I authorize Doctors of Internal Medicine to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for copies.

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed Name (or representative) DOB