REQUEST AND AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

FROM:

Provider/Facility Name _____ Phone Number _____ Fax Number _____

TO:

Provider/Facility Name _____ Phone Number _____ Fax Number _____

Patient Name (Please PRINT CLEARLY) _____ Date of Birth _____ Social Security _____

Patient Address _____ City, State _____ Patient Phone Number _____

INFORMATION REQUESTED:

O Entire Medical Records O Laboratory Test Results O X-ray, CT, MRI, US and Reports

O Therapy Records O Psych NP Records O Lactation Records

O Massage Therapy Records O Other/Specific Information Only: Please Specify _____

_____

O RESTRICTION REQUEST (check if you are exercising this right). You have the right to request that HANDS ON MEDICINE restrict the use or disclosure of your protected health information, including for treatment, payment or our health care operations. Please specify the type of protected health information you would like restricted and the dates of the information:

O Lab results O Billing O Treatment Information O Other (please explain): _____

Dates of Information: _____

State the restriction you want to apply to that protected health information:

_____

If you consent to release of the following records, corresponding circles must be INITIALED:

_____ HIV/AIDS Related Records _____ Genetic Testing Information

_____ Mental Health Information _____ Drug/Alcohol Diagnosis, Treatment or Referral Information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information

By signing below, I agree to release the aforementioned health information and I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I may revoke this authorization in writing at any time, to the extent that action has not been taken in reliance upon this authorization.

If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on _____ (insert applicable date or event). There may be fees for providing copies.

_____ _____

(Signature of patient or person authorized by law) (Date)

O Check here if you are the parent or guardian.