Stone Creek Family Medicine

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **BIRTHDATE**:_____

ADDRESS: _____ **TELEPHONE NO:** (_____)_____

_____

_____

1. I hereby authorize **Stone Creek Family Medicine**:

❑ Disclose/release the specified health information: Receive the specified health information:

TO:_____ **FROM**:_____

_____ _____

_____ _____

_____ _____

_____ _____

Telephone No: (____)_____ Telephone No: (___)_____

Fax No: (____)_____ Fax No: (___)_____

2. The following health information to be disclosed is maintained in the designated record set: (specify the exact information to be disclosed, including dates of service):

❑ Complete medical record Dates of service_____
[OR the records marked below]

- ❑ Consultation Reports
- ❑ History & Physical Examination
- ❑ Progress Notes
- ❑ Report of Procedure
- ❑ Pathology Report
- ❑ Heart Diagram
- ❑ Laboratory Tests
- ❑ Radiology Reports
- ❑ Physicians' Orders
- ❑ Nursing Notes
- ❑ OTHER

❑ (specify)_____

_____

❑ Diagnostic films/Digital Images (specify) _____

❑ Billing Records (specify)_____

3. For the purpose of: _____

4. If you are requesting copies of your own medical record, indicate here if you would prefer to receive via:

- ❑ Encrypted CD/DVD or
- ❑ e-Delivery via a secure portal. Please provide email address for this option.

_____

(OVER)

5. I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment for drug or alcohol abuse; mental or behavioral health or psychiatric care, excluding psychotherapy notes.

6. This authorization is given freely with the understanding that:
   a) I may revoke this authorization at any time, except where information has already been released.
   b) The revocation must be in writing and a form is available from the medical record department.
   c) This authorization will expire 180 days from date of signature unless otherwise specified; expires ____________________.
   d) Stone Creek Family Medicine may not condition treatment or payment upon obtaining this authorization.
   e) A photocopy or fax of this authorization is as valid as the original.
   f) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

___________________________________ Signature of Patient	______________________________ Signature of Patient's Representative
___________________________________ Date	______________________________ Representative's Printed Name
	____________________________ Relationship to Patient
	______________________________ Date

Stone Creek Family Medicine STAFF

❑ **Verified identity of person picking up records.**

Date verified: ______________ Name and Department: _________________________

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