AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:

Date of Birth:

Patient E-mail Address:

This form will authorize Adjuva Primary Care to provide a copy or summary of my medical records as indicated below:

Records to be released include: Records for the period of

Through

Lab Results; Date(s)

X-Ray Copies; Date(s) Type

Other:

You must initial if you consent to the release of the following information in conjunction with the rest of your medical records:

AIDS or HIV Infection information

Drug, Alcohol or Substance Abuse

Genetic Information(including Genetic Test Results)

Mental health information

Reason for Release of information: (Choose all that apply):

Treatment/Continuing Medical Care
Personal Use
Billing or Claims
Insurance
Legal Purposes
Disability Determination
School
Employment
Other (Specify):

4901 State Highway 114, Ste 102 ▮ Northlake, Texas 76262 ▮ P 817.554.2121 ▮ F 817.813.8183 ▮ www.adjuvaprimarycare.com
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The above information may be released to:

Persons/Organization(s):

Address:

City: State: Zip:

Phone #: Fax#:

Expiration of authorization: (You must specify a date or event, i.e. at the end of litigation):

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed above and no longer protected. I have the right to revoke this authorization in writing except to the point that action has already been taken in reliance upon the authorization. I also understand that treatment or payment cannot be conditioned on the authorization.

Patient Signature: Date:

REVOCATION SECTION:

I hereby revoke this authorization, effective .

Patient Signature: Date:

Printed Name of Patient

Signature of Practice Privacy Officer: Date:

If the Practice is seeking this authorization from you for a use or disclosure of your PHI, we will provide you with a copy of this signed authorization.

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