AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

The below information may be released to:

Adjuva Primary Care

Patient Name:_________________ Date of Birth:__________

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

Facility name where records are located: ___________________________

Facility address:______________________________

City:_______________ State: ______________ Zip:________

Phone:___________ Fax: ____________

Records to be released include:

Records for the period of ___________ Through ____________

- ○ Lab Results
- ○ Imaging
- ○ Other

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

Treatment/Continuing Medical Care

Insurance

Disability Determination

Other (Specify):

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. I authorize the receiving facility, Adjuva Primary Care, to utilize my records with collaborating providers in which I am referred to through their entity.

Printed Name of Patient:____________________

Patient Signature:_____________________ **Date:**_________

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