PEACE VALLEY INTERNAL MEDICINE, P.C.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____
PATIENT'S FULL NAME PATIENT SS# OR MED REC#

_____ _____
PATIENT'S MAILING ADDRESS PATIENTS DATE OF BIRTH

_____ _____
CITY, STATE, ZIP CODE PATIENT'S TELEPHONE #

1. ***I hereby authorize use of disclosure of protected health information:***

FROM: TO:

_____ _____
Practice Name/Organization or Name *Practice Name/Organization or Name*

_____ _____
Street Address City State Zip *Street Address City State Zip*

2. The purpose for which disclosure is authorized: **(*Check where applicable)***
_____ Medical Care _____ Insurance Other: _____

3. I request that the following health information be included:
_____ Complete Medical Record _____ History & Physical Exams _____ Imaging Reports
_____ Immunizations _____ Laboratory Results _____ Pathology Reports
_____ Other: **(Please Specify)** _____

4. I understand that my medical record may contain information related to alcohol/drug abuse, mental health/rehabilitation and HIV/AIDS. This information will be disclosed unless I specify that the information is ***NOT*** to be disclosed by ***INTIALING*** below:
_____ Alcohol/Drug Abuse Treatment _____ Mental Health _____ HIV/AIDS

5. Covering the period of health care from: _____ to _____.

6. I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. ☐ This authorization expires as of: _____ ***OR*** ☐ This authorization has NO expiration due.

8. I understand that my treatment, payment, enrolment or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuance to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read and understand this authorization and authorize the use or disclosure of the covered health information as describe in the authorization.

_____ _____ _____
Signature of Patient or Personal Rep (authorized by law) **Date** **Relationship to Patient if signed by representative**