

CIRCLE CARE Center and CIRCLE CARE Center Pharmacy

RELEASE/AUTHORIZATION OF USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION

Information authorized to be Used or Disclosed

The information covered by this authorization includes:

Medical/Prescriptions YES _____ NO _____ (Excludes Psychotherapy notes)

Lab results YES _____ NO _____

Persons to Whom Information May Be Disclosed:

Print name/Relationship

Print name/Relationship

Expiration Date of Authorization

This authorization is effective ___/___/___ through ___/___/___, unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a WRITTEN notice to our office.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is disclosed. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Name of patient (print)

Signature of patient

Date

Signature of patient's representative (if applicable)

Relationship of patient's representative