Headland Family Medicine

Authorization to Disclose Health Information

Patient Name: _____ Social Security Number:_____

1. I authorize **Headland Family Medicine** to use or disclose the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

❑	Problem list	❑	Patient Account Statement/Billing Records
❑	Medication list	❑	_____
❑	List of allergies	❑	_____
❑	Immunization record	❑	_____
❑	Most recent history and physical		
❑	Most recent discharge summary		
❑	Laboratory results	From (date) _____ to (date) _____	
❑	X-ray and imaging reports	From (date) _____ to (date) _____	
❑	Consultation reports	From (doctors' names) _____	
❑	Entire record		

Other: _____

_____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be ***DISCLOSED TO*** and used by the following individual or organization:

   Name: _____

   Address: _____

   Phone Number: _____ Fax Number: _____

   For the purpose: _____

   ❑ At the request of the individual

5. I understand that I have the right to 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 Headland Family Medicine's Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Headland Family Medicine's Privacy Officer..

Signature of Patient or Legal Representative	Date
If signed by Legal Representative, Relationship to Patient	Signature of Witness

For Healthcare Organization Use Only

Date Received: _____

Patient or Patient Representative Verified by:

- ❑ **Signature on File**
- ❑ **Driver's License**
- ❑ **_____**
- ❑ **Patient given copy of signed release**

Staff Member Processing Request: _____