AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date of Release (Today's Date) _____

Patient Identification:

Printed Name: _____ Date of Birth _____

Home Telephone: _____ Okay to leave a voicemail? Yes/No_____

Mobile Telephone: _____ Okay to leave a voicemail? Yes/No_____

Work Telephone: _____ Okay to leave a voicemail? Yes/No_____

Please list individuals whom you wish information to be released to:

I, the undersigned authorize and request Doctors Care to Release information to and Obtain information from the following individuals. This information can include complete health record, reminders of appointments, status of specialist referrals, pertinent documentation, lab results, history and physical, progress notes, discharge summary, X-rays films/reports, billing record, itemized bills, financial documents required for the Doctors Care program: Other, (specify) _____

Name & Telephone Number: Voicemail Okay?

_____Yes/No _____

Name & Telephone Number: Voicemail Okay?

_____ Yes/No _____

Name & Telephone Number: Voicemail Okay?

_____ Yes/No _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIV/AIDS Records Release:

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those

records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Doctors Care. Unless revoked, this authorization **will expire one year from date of signature**, unless otherwise specified.

Re-disclosure:

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure.

I can inspect or copy the protected health information to be used or disclosed. I authorize Doctors Care to use and disclose the protected health information specified above.

Signature: _____Date:___/___/___

(Patient, parent if minor child, or legal guardian)

Relationship to Patient: _____