AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT DETAILS

PATIENT NAME ______________________________

OTHER NAME(S) USED ______________________________

DATE OF BIRTH (MM/DD/YYYY) ______________________________

ADDRESS ______________________________

CITY ______________ STATE ______ ZIP ______

PHONE ( ) ______________________________

EMAIL ADDRESS ______________________________

I, ____________________________ hereby authorize Dr. Michael Musgrove and his authorized representatives to disclose and/or obtain my individually identifiable health information as described below, which may include information concerning communicable disease such as HIV/AIDS, mental illnesses, chemical or alcohol dependency, laboratory results, medical history or treatment, or other such related information or materials. I understand this authorization is voluntary and I may refuse to sign. I understand my health care will not be affected if I do not sign this form.

Under HIPAA, it is important to know: The Privacy Rule does not require the clinic to obtain a signed consent form before sharing information for treatment purposes. Healthcare providers can freely share information for treatment purposes without a signed patient authorization.

WHAT INFORMATION CAN BE DISCLOSED?

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Progress Notes
- ☐ Other______________________________
- ☐ Lab Results
- ☐ Diagnostic Test Reports

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

FAMILY MEMBERS:

OTHER (CPS, COUNTY, ATTORNEY ETC.):

☐ Check this box if you would like your medical records to be sent to the provider(s) listed below:

SPECIFIC DOCTORS/THERAPISTS:

I understand this authorization supersedes and revokes all authorizations previously on file. This authorization may not be interpreted as an addition to any previous authorizations on file.

I understand this authorization will expire in 365 days from the date of this authorization unless I specify another date.
I desire this authorization to expire on____________________ [if applicable].

I understand I may revoke this authorization by issuing a written revocation to the office.

I acknowledge that there is no possible endangerment due to disclosure of my health information.

Signature X ____ **Date**________________________