



This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Privacy Act:

▶ _____
PATIENT'S FIRST AND LAST NAME SOCIAL SECURITY NUMBER

▶ _____
STREET ADDRESS

▶ _____ ▶ _____ ▶ _____
CITY STATE ZIP

▶ _____ ▶ _____ ▶ _____
PHONE CELL BIRTHDATE

I hereby authorize (those named below):

to furnish to (those named below):

▶ _____
NAME OF PHYSICIAN / PROVIDER

▶ _____
STREET ADDRESS

▶ _____ ▶ _____ ▶ _____
CITY STATE ZIP

▶ _____ ▶ _____
PHONE FAX

▶ _____
NAME OF PHYSICIAN / PROVIDER

▶ _____
STREET ADDRESS

▶ _____ ▶ _____ ▶ _____
CITY STATE ZIP

▶ _____ ▶ _____
PHONE FAX

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following information from service dates ▶ _____ to ▶ _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of this healthcare facility and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP.

Initial where appropriate:

- ▶ _____ INITIALS HIV records (including HIV test results) and sexually transmissible diseases
- ▶ _____ INITIALS Psychotherapy records / this serves as my signature release under Federal Law
- ▶ _____ INITIALS Alcohol and substance abuse diagnosis and treatment records
- ▶ _____ INITIALS Other / Specify: _____

▶ _____ SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE