HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ Patient's Date of Birth _____

Address _____ Patient's Telephone Number _____

City, State Zip Code _____ Any Other Name(s) Used _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address listed below:

   _____

   Name

   _____

   Address

   _____

   City State Zip Code Email Address

3. I hereby authorize disclosure of the following information:

   ☐ My entire medical record Immunization Records Only Service Dates Only: _____ to _____

   ☐ Specific Information Only:

   _____

   _____

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED. 2) IF YOU REQUEST RECORDS BE SENT TO A TREATING PROVIDER AND YOU DO NOT WANT YOUR ENTIRE RECORD SENT, WE WILL SEND YOUR RECORDS TO YOU FOR DELIVERY TO YOUR PROVIDER; WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.

D PLEASE EXCLUDE THE FOLLOWING INFORMATION:

_____

_____ Signature: _____

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format: via secure electronic delivery; or ☐ other (please specify)

   _____

5. If I have requested records be sent unencrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
6. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
7. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.

_____ _____ _____

8. I understand I may revoke this authorization by notifying my provider OR drmehra@themehraclinic.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
9. My purpose/use of the information is for personal use; or other (please specify) _____
10. This authorization expires on_____ ____, 20 OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) _____

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ _____

Signature of Patient | Date of Patient's Signature

If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate | Date of Legal Guardian 's/Personal Representative's Signature

_____

Patient's Date of Birth