ENHANCED MEDICAL CARE

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Medical Records Department
Authorization for Use and Disclosure of Protected Health Information

(1) Patient Information

Last name: _____ **First name:** _____ **Middle initial:** _____

Former name: _____ **D.O.B.:** _____ **SSN:** _____

Address _____

Home phone # (_____) _____-_____ **Work phone # (_____) _____-_____**

Cell phone # (_____) _____-_____ **E-mail:** _____

(2) I hereby authorize Enhanced Medical Care, L.L.C./Mark Costa, MD to release or disclose records to:

Name/Facility: _____

Address: _____

Attention: _____

(3) Reason for disclosure:

☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation

☐ Vocational rehab, evaluation ☐ Disability determination ☐ At the request of the individual

☐ Applying for insurance ☐ Other (please specify): _____

(4) This authorization is valid for PHI disclosures to the recipient above for a period of six months, and it automatically expires in six months from the date the form is signed. I understand that I may revoke this authorization by providing a written statement to the sender except to the extent that the sender has already completed the action on it.

(5) I understand that protected health information released pursuant to this authorization may be re-disclosed by the recipient(s) on this form to other individuals or organizations that are not subject to privacy protection laws. I understand that if I have received care from another facility on behalf of the sender, if the records of that treatment are part of my medical record, the sender will include it as part of the release. I also herby release the sender from all legal responsibilities and liabilities that may arise from the release of the information.

(6) Signature of patient or personal representative _____ **Date** _____

Relationship to patient (*if requester is not the patient*): _____

If the patient is 18 years or older, the patient must sign the release unless:

(1) the patient is incompetent,

(2) the patient is disabled and cannot sign the form, or

(3) the patient is deceased. (The surviving spouse with legal proof or legal representative must sign to authorize release of records of the deceased patient.)

If the patient is 18 years or younger, the patient must sign release if:

(1) the patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, drug dependence, or AIDS testing.

(2) the patient's records for release include an abortion procedure.

Anyone signing for release of records, other than the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

*** Privileged information includes the following:**

(1) Information concerning HIV/AIDS

(2) Information concerning venereal disease

(3) Information concerning drug or alcohol abuse

(4) Communications between patients and psychotherapists or psychologists

(5) Communications with social workers