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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 the disclosure of the following:

TO: Enhanced Medical Care, L.L.C./Mark E. Costa, M.D, **FROM:**

Name/Facility: _____

Address: _____

Phone # (_____) _____ - _____ Fax # (_____) _____ - _____

(3) Reason for disclosure:

- | | | |
|---|--|---|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> Legal investigation |
| <input type="checkbox"/> Vocational rehab, evaluation | <input type="checkbox"/> Disability determination | <input type="checkbox"/> At the request of the individual |
| <input type="checkbox"/> Applying for insurance | <input type="checkbox"/> 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 hereby 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