Authorization To Release Protected Health Information

Please Note: This form must be completed in its entirety.

Patient Name _____ DOB _______________

Social Security # _____ - _____ - _____ Phone Number (_____) _____ \ _____

I authorize _____ to release the following health Information to _____

Custodian of Records Name and Contact Info Here

Recipient of Records Name and Contact Info Here

- ☐ Copy of Complete Record
- ☐ Lab Results
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ X Ray Report
- ☐ Mental or Behavioral Health Records
- ☐ Billing and Payment History
- ☐ Progress Notes
- ☐ Genetic Test Results
- ☐ Dental Records
- ☐ Operative/Procedure Report
- ☐ Discharge Summary
- ☐ HIV/AIDS Test Results and Treatment
- ☐ Acohol and Drug Treatment

I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health services and treatment for drug and alcohol abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Practice. I understand that revocation will not apply to the extent MCHG has taken in reliance on this authorization. I understand my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage, as the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ A Year _____. If I fail to specify an expiration date, event of condition, this authorization will expire in six (6) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. MCHG may not condition, treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if I authorize MCHG to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations.

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient

_____ _____

Witness Date

Metro Center™ HealthCare Group

Advanced HEALTH

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