**HEALEY MEDICAL PRACTICE**
**AUTHORIZATION FOR RELEASE OF INFORMATION**

**SECTION A:** Must be completed for all authorizations.

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient Name:_____ Date of Birth:_____

Person(s)/organization authorized to use/disclose information (from):_____
_____
_____
_____

Person(s)/Organizations authorized to receive the information: _____
_____
_____
_____

Information that may be used/disclosed:

(Include dates where appropriate, e.g., medications dispensed in December 2002 or EKG Report performed in June 2000.)

□Record of Visit (all)_____ □ Laboratory Report(s)_____
□Record of Visit(s) (specific)_____ □ X-Ray, MRI, CT_____
□Discharge Summary _____ □Echo, Stress Tests, Holters_____
□History/Physical_____ □ EKG Report_____
□Consultation Report(s)_____ □ Mental Health/Alcohol/Drug Abuse Treatment_____
□ Operative Report(s)_____ □ AIDS or HIV Information_____
□ Problem List_____ □ Hepatitis Information_____
□ Progress Notes_____ □ Entire Medical Record_____
□ Immunization Record(s)_____ □Statement of Charges/Payments_____
□ Medication Record(s)_____ □ Other_____

**SECTION B:** Must be completed only if a health provider or a health plan has requested the authorization.

1. The health plan or health care provider must complete the following:

a. The information will be used/disclosed for the following purposes:

□ Continued Patient Care
□ Disability Determination
□ Personal Use
□Attorney/Legal
□ Insurance Claim
□ Other_____

b. Will the health care provider or health plan requesting the authorization receive financial or in kind compensation in exchange for using or disclosing the health information described above? Yes__ No__

2. I understand that my health care and payment for my health care will not be affected if I do not sign this form.
3. I understand that I may inspect and copy any information to be used or disclosed.

**SECTION C:** Must be completed for all authorizations.

1. I understand that I may revoke this authorization at any time by notifying the health Information Management Department in writing. I understand that the revocation will not apply to information that has already been release in response to the authorization. This authorization expires (date):_____

2. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

_____ _____
Signature of Patient or Representative Today's date

_____ _____
Printed Name of Patient's Representative (if applicable) Relationship to Patient