The One You Trust

FIRST CARE

OCCUPATIONAL HEALTH CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT :

Name of Patient/Previous Names _____ Birth Date/Medical Record Number _____

Street Address _____ City, State, Zip _____

AUTHORIZES:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip _____

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip _____

INFORMATION TO BE RELEASED:

_____ Medical History
_____ Surgical Reports
_____ Immunizations
_____ Treatment or Tests
_____ Laboratory Reports
_____ X-Rays or X-Ray Report
_____ Consultations
_____ Entire Record
_____ Prescriptions
_____ Other (Specify): _____

For The Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

_____ Further Medical Care
_____ Legal Investigation or Action
_____ Personal
_____ Insurance Eligibility/Benefits
_____ Changing Physicians
_____ Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right To Inspect or Copy The Health Information To Be Used Or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Derrick Beem, Privacy Officer. Right To Receive Copy Of This Authorization - I understand if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form. Right To Refuse To Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition, treatment payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right To Withdraw This Authorization - I understand written notification necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Derick Beem, Privacy Officer. I am aware my withdrawal will not be effective as to uses and/or disclosures of my health information that the Person(s) and/or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had am opportunity to review and understand the content to this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____