Patient: _____ DOB: _____ Date: _____ MRN: _____

First in Primary Care **Broadway** MEDICAL CLINIC

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AUTHORIZATION TO USE / DISCLOSE HEALTH INFORMATION

I authorize:_____
(*Name of physician/entity disclosing information*) (Street address)

to use and disclose a copy of the specific health information described below regarding:

_____ _____ _____
(Name of Patient/Child) *(Date of Birth)* *(Phone Number)*

consisting of: ☐ Labs Results ☐Immunization History ☐Documents (Progress Notes, Chart Notes, Imaging) ☐All

to: _____
(*Name and address of recipient or recipients*)

from dates: ☐ birth/beginning of care to present ☐from date: _____/____/_____ to present

by: ☐ email: _____ ☐ fax number: _____ ☐mail: (address above)

for the purpose of: ☐Education/School ☐Legal Review ☐Medical Review ☐New Physician ☐Specialist/Consult ☐Work related ☐Other _____
(Comments)

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Mental health information
_____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, and treatment or referral information.
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to _____ (*contact person*) at (*physician/entity disclosing information*) and state that you are revoking the authorization.

I have read this Authorization and I understand it. Unless revoked, this authorization expires _____ (insert applicable date or event) or 180 days.

By: _____ Date: _____

Please indicate: ☐ Patient or ☐ Individual/Personal representative (Name: _____)

Description of Representative's Authority: _____