Authorization for Release/Exchange of Information

Address:

Fax:
Phone:

This authorizes My Health Onsite to (check all that apply):

☐ Release Information ☐ Exchange Information ☐ Release/Exchange Information

Patient Name: _____ Date of Birth: _____

To/With (specific people or organization(s) to receive information):

_____

_____

_____

I hereby authorize the release of the following information to the above people or organization(s):

Purpose or Need for Release or Exchange:

☐ Medical Records (to include treatment plan/provider summary, medications, labs, etc.)

☐ STD Testing

☐ HIV Testing

☐ Behavioral Health

☐ Other (Please Specify)

Purpose or Need for Release or Exchange:

☐ Assist in Treatment Planning

☐ Continuity of Care

☐ Other (Please Specify)

***NOTICE – PLEASE READ*:** I understand that this authorization will expire on the date specified in the Expiration Date. If I fail to specify an expiration date or event, this authorization will remain in effect TWELVE months after I sign and date the form.

I understand that I may revoke this authorization at any time by sending a written revocation to _____, except to the extent that action has already been taken on this authorization. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law.

Notice to Recipient of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Laws. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or is otherwise permitted by CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that if I have authorized My Health Onsite to disclose my information to persons who are not required by Federal or State law to keep the information confidential, the information may no longer be protected by law and these persons may disclose my protected health information to others without my consent or authorization. My Health Onsite will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

I understand that My Health Onsite may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

EXPIRATION DATE: This consent will expire on _____

Signature: _____ Facilitator/Witness: _____

Relationship to Patient: _____ Date Signed: _____

Date Signed: _____ Time Signed: _____

Time Signed: _____