



PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Community Care Physicians, P.C. to use and/or disclose certain protected health information (PHI) about me to:

Person or Entity to Receive the Information

Please list other medical providers, family, friends, etc. whom, with your permission, may receive your medical information.



Three horizontal lines for entering the name of the person or entity to receive the information.

This authorization permits Community Care Physicians, P.C. to use and/or disclose the following individually identifiable health information about me. Please specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.:

This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line below. In the event the health information described below includes any of these types of information, and I initial the line below, I specifically authorize release of such information to the person(s) indicated above.

Specific information to be released:

Entire Medical Record from (insert date) _____ to (insert date) _____ (If not specified, all dates.)

Box containing 'Only Include:' and 'Include: (Indicate by Initialing)' sections with checkboxes for Prescriptions, Lab Results, Referrals, Office Notes, Billing, Other, Alcohol/Drug Treatment, Mental Health Information, and HIV-Related Information.

Reason for release of information: At request of individual or Other: _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____

{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Community Care Physicians, P.C.. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Signed by:

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____