LOVELACE FAMILY MEDICINE, PA

Authorization to Disclose Health Information

Patient Name: _____ PHONE#_____

Date of Birth: _____ Chart Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Lovelace Family Medicine, PA 803-364-4852/FAX 803-364-2014
3. The type and amount of information to be used or disclosed is as follows:

- ☐ problem list
- ☐ medication list
- ☐ immunization record
- ☐ most recent history and physical
- ☐ most recent provider encounter
- ☐ procedure record
- ☐ laboratory results Dates: from _____ to _____
- ☐ x-ray and imaging reports Dates: from _____ to _____
- ☐ office notes Dates: from _____ to _____
- ☐ entire record
- ☐ Other: _____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Name: _____

Address**:** _____

_____

Purpose of Release:

☐ Medical Care ☐ Legal representation

☐ Other: _____

6. I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in six months from the date of authorization.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Signature of Witness

_____

Description of Representatives's Authority (attach any necessary documentation)