Medical Records Release

PATIENT NAME: _____ DATE: _____

DOB: _____

Section A: Must be completed for all authorizations

I hereby authorize Park Medical Centers to use or disclose the above named individual's health information as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that if the organization or individual(s) who receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:

_____

_____

_____

Persons/organizations receiving the information:

_____

_____

_____

Ph: _____/ Fax: _____

I authorize the release of information contained in the medical records of the patient identified above including drug, chemical dependency, alcohol abuse, mental health and other records in accordance with Federal Regulations. I expressly authorize information concerning the following serious communicable disease to be released: HIV Infection, AIDS-Related Complex (ARC), and/or Acquired Immunodeficiency Syndrome (AIDS).

Section B: Must be completed only if the Medical Practice has requested the authorization

1. The Medical Practice must complete the following:
   a. What is the purpose of the use or disclosure?: **CONTINUITY OF CARE**

   _____

   b. Will the Medical Practice receive financial or in-kind compensation in exchange for using or disclosing the health information described above?Yes ____ No _X__

2. The patient or the patient's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
   Initials: _____ <<

   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
   Initials: _____ <<

Section C: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____**(date)** or upon the occurrence of the following event:

_____

2. I understand that I may revoke this authorization at any time by notifying the Medical Practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. I further understand that once information is disclosed to the recipient pursuant to this authorization that such information may be subject to redisclosure by the recipient and may not be protected under 45 CFR §164.508.

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing.)

Printed name of patient's representative: _____

Relationship to the patient or description of representative's authority: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION