

Authorization to Use to Disclose Health Information

Patient Name: _____

Date of Birth: _____

1. I authorize the disclosure of the above name individual's health information as described below.
2. The following individual(s) or organization(s) are authorized to make the disclosure.
3. The type of information to be disclosed is as follows (check all the appropriate boxes and include other information where indicated)

- problem list
- medication list
- list of allergies
- immunization records
- most recent history
- most recent discharge summary
- lab results (please describe the dates or types of lab tests you would like disclosed):
- x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- consultation reports from (please supply doctor's names):
- entire record
- other (please describe):
- Information related to treatment for any sexually transmitted disease, included HIV or AIDs *
- Information related to treatment for mental health-related illnesses*
- Information related to treatment for substance abuse*

* Must be checked for that specific information to be release.

4. The information identified above may be used by or disclosed to the following individuals or organization(s):



Access Health Records
5489 Wiles Rd suite 303
Coconut Creek, Fl 33073

5. This information for which I'm authorizing disclosure will be used for the following purpose:

- my personal records
- sharing with other health care provider as needed
- other (please describe):

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This authorization will expire in (insert date or event):

If I fail to specify an expiration date or event, this authorization will expire in six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative

Date

If I signed by legal representative, relationship
to patient: _____

Please forward the requested information via fax or regular mail as follows:



Access Health Records
5489 Wiles Rd suite 303
Coconut Creek, Fl 33073

Fax: 866-808-5270

E-Mail: customerservice@accesshealthrecords.com

Please feel free to contact us at: 877.983.2929

*Under HIPAA you can be charged a reasonable fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.