

## Authorization To Disclose Health Information

Patient Name: \_\_\_\_\_ Health Record Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ S.S. No.: \_\_\_\_\_

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:

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

3. The type and amount of information to be used or disclosed is as follows:  
(include dates where appropriate)

- problem list
- medication list
- list of allergies
- immunization record
- most recent history and physical
- most recent discharge summary
- laboratory results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- x-ray and imaging reports from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
- consultation reports from (doctor's names) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 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:

**Caritas Family Medicine**  
**Elissa Speach MD**  
**1501 East Ave. Suite 105**  
**Rochester, NY**  
**Phone/Fax: (888) 263-4441**

[www.caritasfamilymed.com/](http://www.caritasfamilymed.com/) [elissaspeach@onebox.com](mailto:elissaspeach@onebox.com)

For the purpose of: Transfer of Primary Medical Care

6. I understand I have the 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 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. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carriers with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C., 20201  
Phone: (866) 627-7748  
Web: [www.hhs.gov](http://www.hhs.gov)

8. California/Arizona Restriction. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. You are further authorized to discuss my case in detail with \_\_\_\_\_

\_\_\_\_\_ or their representatives, and assist them in any way they may request your services.

\_\_\_\_\_  
*Signature of Patient or Legal Representative*

\_\_\_\_\_  
Date

\_\_\_\_\_  
*If Signed by Legal Representative, Signature of Witness*

Relationship to Patient: \_\_\_\_\_

***A photocopy of this Authorization will be considered as an original.  
This Release complies with the HIPAA Privacy Rules***