

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Section 1: PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: Street: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Telephone Contact #: Day: _____ Email: _____

Section 2: AUTHORIZATION

<p>FROM (Physician/ Office providing the information):</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____ Fax: _____</p>	<p>TO (Person(s) organization receiving the information): PLEASE PROVIDE COMPLETE MAILING ADDRESS</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p>
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Section 3: PURPOSE

<p>A. (Please check the appropriate box)</p> <p><input type="checkbox"/> I am receiving treatment by a specialist</p> <p><input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> Legal Matter</p> <p><input type="checkbox"/> Personal</p> <p><input type="checkbox"/> School</p> <p><input type="checkbox"/> Other (please specify) _____</p> <p>_____</p>	<p>B. I am transferring my care to another healthcare provider</p> <p>May we ask why you are leaving?</p> <p><input type="checkbox"/> Moving</p> <p><input type="checkbox"/> Change of insurance</p> <p><input type="checkbox"/> Dissatisfied (please explain) _____</p> <p>_____</p> <p><input type="checkbox"/> Other (please specify) _____</p> <p>_____</p>
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Section 4: INFORMATION TO BE RELEASED (Please Select Only 1 Option)

There is NO Charge for:

An abstract, patient summary, immunization record, most recent physical, labs and preventative screening.

There IS a charge for:

Medical Record – The last three years of the record will be sent.

Date Range of _____ to _____

(Cost will vary depending on the requested documents. Invoices will be mailed)

Section 5: CONFIDENTIAL RELEASE

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

- Yes No HIV/AIDS diagnosis and treatment.
- Yes No Genetic test results and records relating to any genetic condition.
- Yes No Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This request may be revoked upon oral or written request.
- Yes No Other(s): Please List _____
- Yes No Details of Mental Health Diagnosis and/ or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release mental health records for payment purposes*).
- Yes No Confidential Communications with a Licensed Social Worker.
- Yes No Details of Domestic Violence Victims' Counseling.
- Yes No Detailing of Sexual Assault Counseling.
- Yes No Details of Sexually Transmitted Disease (includes HPV/Chlamydia).

Incomplete forms will be returned and could delay your request.

Section 6: SIGNATURE

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
 - to the extent that action has been taken in reliance on this authorization
 - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if disclosed by the recipient, is no longer protected by Milford Regional Physician Group, Inc.
- I understand that this authorization will automatically expire in 12 months unless otherwise specified.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above mentioned information about, or medical records of, my condition to those personas or agencies listed above.

Patient's Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Print Name: _____ Relationship of representative to patient: _____

Please note: Milford Regional Physician Group may charge a fee for copies