**AUTHORIZATION TO DISCLOSE**

**PROTECTED HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

1. **Release From**: The following individual(s) or organization(s) are authorized to disclose the protected health information of the above named individual as described in this authorization:
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone / Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Release To**: The protected health information may be used by or disclosed to the following individual(s) or organization(s):
Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone / Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Covered health information:** The following protected health information is covered by this authorization (except as limited below):
	* Complete medical record
	* Problem list
	* Medication list
	* List of allergies
	* Immunization records
	* Most recent history/diagnosis
	* Discharge summary for admission on \_\_\_\_\_\_\_\_\_
	* Lab results (Please list specific tests and dates below.)
	* X-ray and imaging reports (Please list specific studies and dates below.)
	* Consultation report (Please supply consulting physician’s name and date below.)
	* Operative report: Procedure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_
	* Progress note(s): Date \_\_\_\_\_\_ or Range of Dates \_\_\_\_\_\_\_\_\_\_\_\_\_
	* Treatment Plan

*Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded on page 2.*

* + Other (please give specific description)
	\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **Specially protected information**: The following information is specially protected by state and/or federal law. I specifically authorize the release of the following information:

|  |  |  |  |
| --- | --- | --- | --- |
| Substance abuse records(drug or alcohol) | Yes ❑ | No ❑ | Initials \_\_\_\_ |
| Mental health records protected by the Mental Health Procedures Act | Yes ❑ | No ❑ | Initials \_\_\_\_ |
| HIV/AIDS related information | Yes ❑ | No ❑ | Initials \_\_\_\_ |

1. **Other restrictions**: Please specify any other restrictions on the covered information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Purpose of disclosure**: I am requesting use or disclosure of the covered health information for the following purpose:
	* Further medical treatment
	* Insurance eligibility or benefits
	* Eligibility for disability benefits
	* Legal investigation or action
	* Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. I understand that I have the following rights:
* **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Integrated Medical Group, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
* **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:
 Integrated Medical Group, PC
 Attention: Privacy Officer
 82 Tunnel Road, Pottsville PA 17901
1. **Expiration**. This authorization expires on January 31, 2030.

**I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or personal representative) Date

Personal Representative Information (as applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of personal representative (Print) Relationship to patient (Print)