Republic Family Medicine llc
Yvonne Agius, M.D.
www.docagius.com
117 West State Highway 174 • Republic, Missouri 65738-1036 • Phone (417) 647-5131 • Fax (417) 647-5168

# HIPAA COMPLIANT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____

Previous Name: _____ Social Security Number: _____

For the purpose of reviewing my records, I request and authorize:

Previous Provider/Clinic/Organization: _____

Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

to release health care information of the patient named above to:

Republic Family Medicine, LLC
Yvonne Agius, M.D.
117 W. State Hwy. 174
Republic, MO 65738-1036
P: (417) 647-5131 F: (417) 647-5168

This request and authorization applies to:

( ) All Healthcare information

( ) Healthcare information relating to the following treatment, condition, or dates:

_____

( ) Other: _____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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. To revoke this authorization I may contact Republic Family Medicine, LLC in writing.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).
7. A copy or facsimile of this authorization shall be counted true and valid as original. This authorization will expire 180 days from the date signed.

Patient Signature: _____ Date: _____/_____/_____

Guardian Signature (if minor): _____ Date: _____/_____/_____

Legal Relationship of Guardian: _____