Authorization for Release of Patient Information

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AnointedHands.Net

Name **DOB**

Maiden Name **SSN**

I authorize the following person/organization to send/fax my medical records to Anointed Hands Medical Services:

Name

Address *Suite*

City *State* *Zip Code*

Telephone Number *Fax Number*

To disclose the above named individual's health information as described below, please provide the following information:

Date(s) of service requested (if known) or Provider _____

Description of Information to be released (check all that apply)

- ☐ Immunization records
- ☐ Most recent history and physical
- ☐ Laboratory reports
- ☐ Consultations
- ☐ Radiology/Imaging reports
- ☐ Progress notes
- ☐ Radiology Films
- ☐ Entire Medical Record
- ☐ Other_____

Description of the purpose of the use and/or disclosure

- ☐ Continuing Care
- ☐ Second Opinion
- ☐ Social Security/Disability
- ☐ Consultation
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ Other: Please Describe _____
  _____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDs), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information. This information may be used by or sent to Anointed Hands Medical Services:

- ☐ Dr. Lorrie Richardson-O'Neal
- ☐ Dr. Kenneth O'Neal

I FULLY UNDERSTAND that my medical record may contain psychiatric, mental health, developmental disabilities, alcohol and/or substance abuse information, and/or AIDs/HIV test results and/or information. Only records and or information believed necessary for the purpose expressed above should be released and disclosed. This release may NOT include hospital records OR records from another physician.

I understand that my refusal to consent to the release of the above mentioned information would prevent the disclosure of this information. I understand that if this authorization is for purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review agency, and if I refuse to authorize the release of information for this purpose, it may adversely affect my entitlement to insurance benefits.

I understand that I may revoke this authorization at any time except to the extent that this action has already been taken in reliance thereof. Authorization for release expires 90 days or ____/____/_____, unless I revoke it.

Signature of Patient or representative Date

Printed Name of Patient or representative Relationship to patient

**legal authority to represent: attach document if appropriate