Limited Patient Authorization for Disclosure of Protected Health Information

Patient Name (please print)

_____ _____ _____ _____ _____ _____
Name Birthdate SS#

Purpose of request - I authorize **Family Health** to disclose or provide protected health information, about me, to: (to whom do you want it to go? and how do you want it to go?)

_____ ____ Mail it _____
Provider Name / Organization Mailed/Date

_____ ____ Fax it to_____
Address Number/Date

_____ ____ Pick up on_____
City, State, Zip Date

Description of information to be disclosed - I authorize **Family Health** to disclose the following protected health information about me to the person identified above (what do you want to be released, be specific):

Date(s) of Service: _____

____ Progress Notes ____ Laboratory/Pathology ____ Billing
____ History/Physical ____ EKG/GXT ____ X-ray
____ Medicines ____ Complete Medical Record
____ Other: _____

If release of information is to include Psychiatric, Alcohol, Drug Abuse, or HIV results, Initial Here: _____ (You must specify above, under Other:)

Purpose of disclosure – (why are you releasing this information about yourself):

____ Continue medical care ____ Transferring to another provider/clinic
____ Personal use ____ Surgery
____ Other: _____

Expirations or termination of authorization – This authorization will expire at the end of one year from the time you sign it (below), unless you specify an earlier termination. You will have to submit a new authorization after the expiration date to continue the authorization. Date you want this authorization to end if earlier than one year: _____

Right to revoke or terminate –You have the right to revoke or terminate this authorization (providing the information has not already been disclosed) by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Family Health
407 S. Medical Arts Court, Suite D
Gillette, WY 82716-3372
Attn: Privacy Manager.

Redisclosure – We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of **Family Health**.

_____
Patient signature Relation/Authority Today's Date