Authorization to Disclose Protected Health Information

PATIENT INFORMATION

Name

Date of Birth (mm/dd/yyyy)

Phone Number

RECIPIENT INFORMATION

Name

Street Address

Apt. or Suite #

City

State

Zip Code

Phone Number

Email Address and/or Fax Number

RECORDS TO BE DISCLOSED (PLEASE CHECK ONE)

- ☐ Records related to:
- ☐ Records for these dates
- ☐ Other; please specify:

RELEASE OF SENSITIVE INFORMATION

If your medical record contains the following types of records, they will be disclosed only if you initial next to each:

Information relating to Acquired Immuno-deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken. Initial

Genetic testing information including test results. Initial

Information about sexually transmitted diseases Initial

DELIVERY OF RECORDS (PLEASE CHECK ONE)

☐ Please send to Recipient by this method: Mail ☐ Facsimile ☐

☐ I will pick up the documents in person

☐ Someone else will pick up the documents in person. Name:

☐ Secure, encrypted email.

☐ Regular (non-encrypted) email. Note we do not recommend regular email, as your records may not be protected from interception during transmission. If you wish to assume this risk and request we send your records by regular email, please sign here:

☐ Other method; please specify:

SIGNATURE

I understand that:

1. This Authorization is voluntary. I understand that my treatment by this health care provider does not depend upon my signing this Authorization. If I do not sign it, my records will not be released as directed in this Authorization.
2. This Authorization will expire on: _____ or 6 months after the date of my signature, whichever occurs first.
3. After signing, I may revoke this Authorization at any time by providing a written notice of revocation to Danielsen Institute administrative staff; however any revocation will not affect disclosures made in reliance on this Authorization before receipt of my written revocation.
4. The information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

Signature of individual or Legally Authorized Representative

Date

If Legally Authorized Representative, please specify relation to

Date

FOR OFFICE USE ONLY

Staff member who receives the request needs to:

1) Review Authorization to make sure all necessary information has been filled in, patient signed.
2) If signed by patient's Legally Authorized Representative, verify copy of documents establishing representative's authority are in patient medical record.
3) Sign your name below and fill in date received.

Received By (name, title)

Date Authorization Recieved

Staff member who fulfills the request needs to:

1) Complete the section below to confirm you have verified the records are going to the correct recipient, by the requested method.
2) Sign your name below and fill in date request fulfilled.
3) Scan this Authorization and keep it in patient's medical record.
4) Provide a copy of this completed form to patient/recipient along with the records.

Please check all that apply: 1/X

- ☐ Patient or patient's friend/family member known to me picked up the documents in person.
- ☐ Records were picked up in person by someon not known to me; I verified identify by picture ID.
- ☐ I mailed the records after verifying the name and address of the Recipient.
- ☐ I emailed the records to the Recipient after confirming the e mail address.

Request Fulfilled By (name, title)

Date Request Fulfilled