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)

Physical copy to be delivered to Recipient by: Mail Facsimile

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 patient. Date

FOR OFFICE USE ONLY

Date Auth Rec'd Received By (name, title) Patient/Client Name, Record Number

Please check all that apply:

Patient or patient's friend/family member known to me picked up documents in person

If records are picked up in person by someone not known to you, verify identity by picture ID:

If mailing records, verify name and address of recipient

If e mailing records, verify e mail address. Use encrypted email unless patient has authorized non-decure e mail in writing.

If signed by patient's Legally Authorized Representative, verify copy of court appointment or other documentatoin of representive's authority. Contact HIPAA Privacy Officer with questions.

Scan this Authorization and keep it in patient's medical record.

Provide a copy to patient/recipient along with the records.

Name of person filfilling the request **Date Completed**