Authorization for the Release of Protected Health Information

Patient's Name: ______________________________________

Date of Birth: ____ **Phone:** ___________________________

I, ____**, hereby authorize Carson Medical Group to disclose the following protected health information:**

Date Range __________________ **to** _________________________

- ☐ **Visit Notes**
- ☐ **Lab Results**
- ☐ **Imaging Results**
- ☐ **Financial/Billing Records** *(Not available for other medical offices)*
- ☐ **Other** ____

Disclose to: ____

(Person or organization authorized to receive the information)

Purpose of disclosure: ____

Method of disclosure (please check one):

- ☐ **Email:** ____
  (If the file is too large to email flash drive will be provided)
- ☐ **Fax:** ____________________________________
- ☐ **Mailing Address:** ____
  ____
- ☐ **Patient Pick up (Paper Copy)**

I acknowledge that I have the right to revoke the authorization at any time; and that I understand that once the information is disclosed, it may no longer be protected by the federal privacy law. You may revoke this authorization only in writing sent by certified mail to the Provider at the address above. The revocation will be effective only upon receipt, (1) to the extent the Provider as acted in reliance on the authorization, or (2) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals and (3) except for psychotherapy notes, for health plans who condition enrollment or an authorization, or where payment condition on an authorization to use this information to determine payment. I also consent to the release and any and all information regarding alcohol, drug abuse, psychiatric/mental health, communicable disease, hepatitis, AIDS and HIV. I understand that such information cannot be released without my specific consent and that my signature below grants permission to release the above information, if any exists. I understand that Carson Medical Group will not condition treatment upon the execution of this authorization agreement. The undersigned authorizes Carson Medical Group to release information. Authorization will expire one year from date signed.

Signature: ____ **Date:** ________________________

Name of Legal Representative (if not signed by patient): ____

Relationship to patient: ____

For office staff only: Name:_______________________ **Date:** __________________