Carson Medical Group

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 to:**

Person or Entity authorized to receive Protected Health Information: _____

☐ Fax Number: ( ) -

☐ Mailing Address: _____

_____

☐ Email Address: _____

Information to be disclosed (check all that apply):

☐ Medical Records ☐ Other: _____

☐ Treatment Records _____

☐ Diagnostic Records _____

☐ Financial/Billing Records

Purpose for disclosure: _____

Dates of treatment: _____

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.

Print Patient's Name: _____ Patient Date of Birth: _____

Patient Signature: _____

Guarantor/Guardian Signature: _____ Relationship: _____

Print Guarantor/Guardian Name: _____

Date Signed: _____

For office staff only:
Date received (initial & date)
Patient/Guardian Identification

By typing your name for your signature, you are signing this form electronically.
You agree your electronic signature is the legal equivalent of your manual signature on this form.