Healthy Living Health Care

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name (please print):_____

Date of Birth: _____ Phone _____

I authorize Healthy Living Health Care to release my medical records to:

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

The purpose of this release is to facilitate transfer of care due to our practice closing. All information in our possession (history, date of service, test results and correspondence) will be sent unless restricted below.

You have the right to limit the release of sensitive information. If you have been tested, diagnosed, or treated for any of the following, we need your specific consent to release those portions of your medical record. You also have the right to review any such records before they are disclosed.

PLEASE INDICATE:

__ None of these things apply to me/no limitations on information release.

OR (indicate any which apply)

__**I do not** authorize disclosure of information regarding HIV testing and results.

__**I do not** authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol use. Such information may not be re-disclosed by the recipient without my specific written consent.

__**I do not** authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.

__**I do not** agree to have such information released without my prior review

I understand that: • I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. • I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed notification to Healthy Living except to the extent that Healthy Living has already acted in reliance on it. • I am entitled to a copy of this authorization, upon request. • I can cross out any provision on this form with which I disagree. • Recipients may not be subject to state and federal Privacy laws and therefore information may be re-disclosed without my consent.

This authorization is effective until _____(or twelve months from the date below if I do not specify a date), and I authorize future disclosures regarding these records to the same individuals and/or entities during this time period.

Signature of patient or legal representative Date Relationship (i.e., self, parent)