DayOne Family Healthcare, P.C.
363 Fremont Street, Suite 203
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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT FULL NAME____

DATE OF BIRTH______________________SS#___________________________

I HEREBY AUTHORIZE:

____
(Practice Name and Address)

TO RELEASE MEDICAL INFORMATION TO:

____
(Practice Name and Address)

INFORMATION TO BE RELEASED (PLEASE INITIAL APPROPRIATE LINE):

________ENTIRE MEDICAL RECORD EXCLUDING INFORMATION RELATED TO HIV OR AIDS INFECTION, OR THE FOLLOWING (IF APPLICABLE):

________LAST ONE YEAR PROGRESS NOTES, TWO YEARS OF ALL TESTING, THREE YEARS CORRESPONDENCE FROM SPECIALISTS, IMMUNIZATION RECORDS, GROWTH CHARTS (FOR CHILDREN UNDER 5)

________MEDICAL INFORMATION RELATED TO HIV/AIDS INFECTION

________ANY RECORD OF TREATMENT FOR DRUG AND/OR ALCOHOL DEPENDENCY OR ABUSE

________ANY RECORD OF MENTAL HEALTH TREATMENT

________SPECIFICALLY ONLY THE FOLLOWING:___________________________

PURPOSE OF RELEASE: ___TRANSFER CARE REASON FOR TRANSFER______________

____

___COORDINATION OF CARE ___ SHARED INFORMATION
___REFERRAL ___ NO REASON GIVEN

The practice will______, or will not______ receive payment or other remuneration from a third party in exchange for using or disclosing PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed in relation to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except when the practice has already taken action upon this authorization. I acknowledge that I may receive a copy of this authorization. This release is effective for one (1) year from the date of signing.

____ ______________________
Patient Signature or Parent/Legal Guardian Dated

____ ______________________
Witness Relationship to Patient

6/16/08