Care Medical Group

Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____
(First Name Middle Initial Last Name) (mm/dd/yyy)

Previous Name/s (if applicable): _____ Phone: _____
(Include area code)

I authorize Care Medical Group to disclose Protected Health Information (PHI) from the above named patient to the following individual/s:

Name: _____ Relation to Patient: _____
(First Name Middle Initial Last Name)

Address: _____ City: _____ State: _____

Zip Code: _____ Phone ( ) _____ Fax: ( ) _____

Care Medical Group may disclose the following PHI to the above entity (at least one box must be checked to process request):

□ **ALL** PHI in my medical record. This includes treatment regarding HIV/AIDS, sexually transmitted diseases, mental health disorders, drug and/or alcohol use if previously treated or currently under treatment.

□ Only PHI in my medical record relating to the following condition: _____

_____

_____

□ Health care information in my medical record for the date(s): _____

□ Other (please be specific and list exact dates): _____

_____

I request that Care Medical Group exclude the following information (at least one box must be checked to process request):

□ No exclusions requested

□ HIV/AIDS related treatment information

□ Sexually transmitted diseases

□ Mental health treatment

□ Drug and/or Alcohol use

□ Other (be very specific): _____

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I understand that this is an authorization for disclosure of my Protected Health Information (PHI) in the manner stated on this release. This is not an authorization for treatment, payment of treatment or for any other type of health care benefits. This authorization to disclose PHI expires (one box must be checked to process request):

- □ on (specific date): _____.
- □ in 90 days from the dated signature below.
- □ in one year from the dated signature below.

By signing below, I authorize Care Medical Group to disclose this PHI. I may revoke this authorization in writing at any time. If I elect to revoke this authorization prior to the date specified above, it does not effect any actions already taken by Care Medical Group by my authorization. To revoke this authorization, I agree to fill out the Authorization to Disclose Protected Health Information Revocation form available from Care Medical Group, or I will provide in writing to Care Medical Group the details of my revocation. Once my PHI is disclosed, the entity I authorized Care Medical Group to release information to may re-disclose the information and privacy laws may no longer govern it use and/or disclosure.

Signature: _____ Date: _____
(Full signature by patient or legal patient representative) (mm/dd/yyyy)

Print Name: _____ Relation: _____
(First Name Middle Initial Last Name) (i.e. self, legal guardian)