Mountain View Family Practice, P.C.

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AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI)

PATIENT NAME: _____
PATIENT DOB: _____
ADDRESS: _____
PHONE: _____

Information to be Used or Disclosed:

The information covered by this authorization includes:

☐ ALL RECORDS	☐ *HIV/AIDS _____
☐ PROGRESS NOTES	☐ *MENTAL HEALTH/PSYCHIATRIC _____
☐ X-RAY REPORTS	☐ *ALCOHOL/DRUG INFORMATION _____
☐ LAB REPORTS	☐ *ABORTION _____
☐ IMMUNIZATIONS	☐ *SEXUAL ASSAULT _____
☐ OTHER(PLEASE SPECIFY)	☐ *OTHER(PLEASE SPECIFY) _____

*INDICATES PHI THAT INITIALS ARE REQUIRED IN ORDER TO RELEASE THIS INFORMATION

Purpose of the Disclosure:

☐ TRANSFER TO NEW PHYSICIAN
☐ PERSONAL USE
☐ MEDICAL TREATMENT
☐ OTHER (PLEASE SPECIFY)

Persons Authorized to Disclose the Above Information:

_____

_____

(Name of person or organization)

Persons to Whom Information May Be Disclosed:

_____

_____

(Name of person or organization)

I understand that if the person (s) and/or organization listed above are not healthcare organizations, health plans or healthcare clearing houses (that must follow the federal privacy stands), the health information disclosed as a result of this authorization may no longer be protected by the federal privacy act and my health information may be redisclosed without obtaining my authorization.

Expiration Date of Authorization:
This authorization is effective through (check one) ☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should submit your written revocation to the HIPAA Compliance Officer.

Rights/Potential for Re-disclosure
I understand I have the right to inspect or copy my health information that I authorized to be disclosed with this form. I can expect to have my health information available to me by calling Mountain View Family Practice, PC and arranging a time to do so. I understand that there may be a fee to copy my information and that it could take up to 30 days to do so. I understand that if I agree to sign this form, which I am not required to do, I have a right to receive a copy of this form. I understand that I am under no obligation to sign this authorization and that the person (s) and or organization listed on this form will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

I have completed, reviewed and understand the information contained in this form. I agree to the release of this information.

Signature of Patient/Parent/Legal Guardian:
_____Date_____

Relationship of Patient (if signature other than patient, i.e. Parent/Legal Guardian)
_____

Witness: _____Date_____
