CLEVELAND MEDICAL ASSOCIATES, PLLC.

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Authorization to Use and Disclose Protected Health Information

Patient's Name: _____ **Date of Birth**: _____
Patient's Phone: _____ **Patient's Email:** _____
Patient's Address: _____

I authorize the use and disclosure of Health Information about me as described below. (Copy charges may apply)

Facility authorized to release my health information: _____

Agency or Individual(s) authorized to receive my health information: _____

Health information that may be used or disclosed is limited to the following: (Circle One)
Discharge Summary | **History and Physical | Consultation(s)** | **Operative Notes** | **Pathology Report** | **Imaging** | **X-Ray** | **Lab(s)** | **Entire Record** | **Other** _____

If it exists, the following sensitive information can be disclosed (Circle All That Apply):
Alcohol Abuse | **Drug Abuse** | **Communicable Diseases (Including HIV Status)** | **Genetic Testing** | **Psychiatric/Behavioral Diagnosis**

I would like to receive my records: **Mail to Myself | Pick Up in Person | Mail to Third Party | Fax to Third Party**
Recipient's Name: _____ Fax #: _____ Address: _____

Health information that may be used or disclosed is limited to the following treatment dates: _____

Health information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s) (include research or marketing, if appropriate) **CONTINUITY OF CARE**

Health information identifies you (the patient) by name and includes other demographic information about you. I hereby discharge the releasing facility, its agents, and employees from any and all liabilities, responsibilities, damages, and claims which may arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnosis complied during my visit, encounter, or hospitalization, or make copes thereof in accordance with the policies of this facility.

Protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. If research-related health information is used or disclosed for continued research purposes, and expiration date or event does not apply. I understand that I have the right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the health information portability accountability act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage. Notice to receiving agency or individual: This information is to be treated in accordance with health Information Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature: _____**Date**: _____

Relationship to Patient/Authority to Act on Patient's Behalf: _____

Witness Signature (If App): _____ **Expiration Date**: _____
*** If legal representative, we require a copy of the documentation to support the representation.**