Downtown Medical Group

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Authorization for Use of Disclosure of Protected Health Information

I, _____, date of birth ___/___/___, authorize **Downtown Medical Group** to
(Patient's Name) mm/dd/yy

release the protected health information described below to

☐ Myself

OR

☐ _____
(Provider/Facility's name)

_____
(Provider/Facility's address, phone & fax number)

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol and/or drug abuse). _____ (initial)

OR

☐ I authorize the release of my complete health record with the exception of the following information:

_____ (initial) ☐ Recent Lab/x-ray reports
_____ (initial) ☐ Records related to my _____
_____ (initial) ☐ Mental health records ↑my medical condition(s)↑
_____ (initial) ☐ Communicable diseases (including HIV and AIDS)
_____ (initial) ☐ Alcohol/drug abuse treatment
_____ (initial) ☐ Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force now and effect until the receipt of the requested information.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization must be completed with a valid patient signature and accompanied by $30.00 for retrieval, copying, clerical, and postage costs. The records shall be transmitted within 15 days of receipt of the written request for copied records.

_____ _____ _____
Patient Name (Printed) **Signature** **Date**