AgLands Family Health
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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	DOB:	Last 4 of Social Security Number:
Address:	City, State, ZIP:	Phone Number:

I hereby authorize the facility listed below to disclose/ release the Protected Health Information specified in this request to the organization, facility, or person named below.

Release **FROM**:	Release **TO**:
NAME OF FACILITY/ORGANIZATION/PERSON:	NAME OF FACILITY/ORGANIZATION/PERSON:
ADDRESS:	ADDRESS:
PHONE/FAX:	PHONE/FAX:

PURPOSE OF DISCLOSURE:

□ Continuation of Medical Care □ Personal Use □ Legal □ Insurance □ Disability □ Other (Specify):___________

INFORMATION TO BE DISCLOSED:

□ Entire Medical Record □ Office Notes /Treatment Plan □ Laboratory Results □ Imaging Results □Billing Records
□ Other (Specify):______________________

DATES OF TREATMENT:

□ Most Recent Year □ All Dates □ Other (Specify):_____________________________

IF ANY OF THE FOLLOWING INFORMATION IS TO BE DISCLOSED, CHECK *ALL* THAT APPLY BELOW:

□ Alcohol/Drug Addiction Treatment □ Psychotherapy Notes ONLY □ Sexually Transmitted Disease Treatment
□ Mental Health □ HIV/AIDS – Related Treatment

- I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol abuse/treatment.
- I understand I have the right to revoke this authorization in writing.
- I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. To revoke an authorization I will write a letter to the facility/Provider.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under the Privacy laws.
- I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
- I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment) However my signature is required to receive health care when the purpose is to create health information for a third party.
- This authorization will expire 1 year from the date signed unless other date specified here:________________. A copy or facsimile of this authorization shall be counted true and valid as the original.

Signature of Patient/Legal Representative ____**Date** __________________

Relationship to Patient (IF SIGNED BY LEGAL REPRESENTATIVE) ____
PRINTED Name of individual (IF SIGNED BY LEGAL REPRESENTATIVE)____