Patient Name_____

Address_____

Phone Number_____

Date of Birth_____

Medical Record Number_____

SCT Medical Clinic
Occupational Health and Minor Care Clinic

# AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

**FROM:** Person/Institution_____

Address_____

City_____State_____Zip_____

**TO:** (**Recipient**) Person/Institution_____

Address_____

City_____State_____Zip_____

Purpose or need for information:_____

Disclosure will include: (*check all that apply*)

☐Face Sheet ☐History & Physical ☐Laboratory Report ☐Operative Report ☐ Imaging Studies
☐Discharge Summary ☐Progress/Physician Notes ☐ X-ray/Radiology Report ☐Pathology Report ☐Other _____
☐Emergency Report ☐Nurses Notes ☐EKG/EMG/EEG Report ☐Consultation Report ☐Pre-Employment testing & physicals

Records for the period (dates) from_____to_____

**I must check one or more of the following types of health information if I do not want that information released to the above named Recipient. I understand that if I do not check any of the following three (3) boxes, the health information released to the named Recipient may include any of the following:**

_____**Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse.**

_____**Records of HIV testing (AIDS test) and the diagnosis and/or treatment of AIDS/AIDS- related conditions.**

_____ **Psychiatric, psychological records or records of the evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.**

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in 1 year after signing**. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient
(Required if Patient is not legally authorized to sign Authorization)

_____
Witness

**REDISCLOSURE:** Notice is hereby given to the patient or legal representative signing this Authorization that SCT Medical Clinic cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

# Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

| |
|---|
| Name of person(s) to receive the requested PHI: |
| Name of entity from whom PHI is requested for use or disclosure: |
| Name of the patient whose PHI is requested & description of the specific PHI requested: |

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because:

[X] The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

I understand that I may be subject to criminal penalties pursuant to 42 USC 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Printed name of the person requesting the PHI: _____

Signature of the person requesting the PHI: _____ Date: _____

*This attestation document may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.*