Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Doctors Park Family Medicine to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

Authorized to release: | **Authorized to receive:**

Doctors Park Family Medicine
Releasing Information

3201 Middle Rd
Address

Columbus, IN 47203
City / State / Zip

Phone: 812-372-8281
Fax: 812-372-4525

____
To receive information

____
Address

____
City / State / Zip

This authorization permits releasing facility (noted above) to use or disclose copies of the following individually identifiable health information:

_____ Contents of entire medical record including information on drug, alcohol, mental health and infectious disease.
_____ Contents but exclude information on drug, alcohol, mental health and infectious disease
_____ Contents but exclude information from any other doctors, facilities, etc.
_____ Other (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). :______________________

____

For the purpose of:______________________________

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. This consent will expire in 6 months from signature date unless otherwise noted.

Indiana Code #16-39-1-1 provides a written request may be made and provided to you in a specified manner for an appropriate fee, therefore, I understand and agree that I may be financially responsible for fees associated with my request.

I understand this facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorized herein. I understand that this facility may not condition treatment or payment on whether I sign this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that the releasing facility (noted above) has acted in reliance

Patient Information & Authorized Signatures:

______________________ ______________________
Patient Name Date of Birth | Relationship to Patient

______________________ ______________________
Signature of Patient / Legal Guardian | Date

______________________ ______________________
Print Name of Patient / Legal Guardian | Street Address

____
City / State / Zip

Action Taken:______________________ Date:__________ Staff Name:__________