MEDICAL CONSENT AND CONTINUING AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name, Last **First** **MI** **Date of Birth** **Social Security #**

I hereby authorize:
(Name of releasing facilities/med providers)

_____
_____
_____

To Release Information to:

_____
_____
_____

Purpose of Disclosure:
( ) Continuing Care ( ) Payment of Claim ( ) Legal ( ) Insurance
( ) Personal Use ( ) Other _____ (Specify)

Information to be released between dates of:
Information to be released:
( ) Discharge Summary ( ) H&P Exam/Initial Exam ( ) Consult
( ) Procedure Reports ( ) Orders ( ) Entire Record
( ) X-ray/MRI/CT Reports ( ) Correspondence ( ) Progress Notes/Provider Notes
( ) Other_____ (Specify date and content)

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one (1) year from the date of signature. THIS AUTHORIZATION SHALL BE DEEMED CONTINUING IN NATURE REQUIRING THE RELEASING FACILITY TO PROVIDE SUPPLEMENTAL INFORMATION TO THE ORGANIZATION NAMED ABOVE AS IT BECOMES AVAILABLE WITHOUT THE NECESSITY OF THE ORGANIZATION PROVIDING ADDITIONAL AUTHORIZATION(S).
- I understand that I may revoke this authorization at any time by notifying the releasing facility in writing and it will be effective on the date notification is sent. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- A photocopy of this authorization will be treated in the same manner as the original.
- I understand that this information released may contain information related to Substance Abuse, Behavioral Health, and HIV/AIDS if it is in the medical record.

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Signature (Patient, Parent, Personal Rep.) Relationship Date

_____

Reason patient is unable to sign