Authorization to Disclose - Protected Health Information (PHI)

Patient Name: _____ **Date of Birth**: _____

I hereby authorize the following disclosure to Protected Health Information (PHI):

Person / Business Providing Information:

☐ Name: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Phone: _____ Fax: _____

Person / Business Receiving Information:

☐ Patient, or
☒ Name: Core Health - Direct Primary Care
Address: 6234 Massard Rd. Suite 102
City: Fort Smith State: AR Zip Code: 72916
Phone: 479-269-4058 Fax: 833-973-6042

Specific Information to be requested: **Date(s) of Service:** _____

☐ Visit Notes ☐ Radiology Report ☐ EKG Results ☐ Laboratory Report ☐ Medication List ☐ Operative Report
☐ Consultation ☐ H&P ☐ Physician Orders ☐ Immunization Records ☐ Entire Medical Record
☐ Other Information: _____

The Purpose of this disclosure is:

☐ Continuity of Care / Physician ☐ Legal ☐ Insurance ☐ Personal ☐ School / Work
☐ Other: _____

Format:

☐ Paper ☐ Electronic

I understand that my ability to receive treatment is not conditioned on my signing this Authorization. I understand that I may revoke this authorization at any time by sending a written notice to the clinic. I understand that any release which has been made prior to such revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. THis authorization will expire in ONE year.
Notice: Once your PHI has been disclosed in accordance with this authorization, it may be re-disclosed to individuals or organizations that are not subject to the HIPPA regulations, which means the information may no longer be protected by HIPPA.

_____ _____
Signature of patient / Legal Representative Date Relationship, if not the patient

_____ _____
Witness Date Witness Address

Specific authorization for release of Drug / Alcohol Abuse information and / or mental health information: I acknowledge that date to release MAY INCLUDE material that is protected by Federal Law and that is applicable to EITHER Drug / Alcohol or Mental Health or BOTH. My signature authorizes release of all such information (as specified about and for the purpose mentioned above).
In order for the above information to be released, you MUST sign here and above.

_____ _____
Signature of patient / Legal Representative Date