HUNTINGTON MEDICAL FOUNDATION

AUTHORIZATION FOR RELEASE OF INFORMATION

Although your privacy has always been important to us, we are now mandated, due to a recent federal law called HIPAA (Health Insurance Portability and Accountability Act of 1996), to obtain authorization to share your Protected Health Information with others. This means that if you routinely have someone else in involved in your care or the care of your children, we will need to have an authorization on file in order to continue to accommodate you. If any of the following scenarios fit your situation, please complete this authorization form and return it to us for our files.

- ✓ Someone other than the parent or legal guardian brings your children for services at any of our offices. Please list all individuals by name who are authorized by you to be present during a doctor visit.
- ✓ Someone other than the patient, parent or legal guardian picks up lab slips, prescriptions or other information from our offices on behalf of the patient. Please list all individuals by name that are authorized to do so, including a spouse.
- ✓ Someone other than the patient, parent or legal guardian calls on the phone requesting information such as immunization records, test results, appointments, prescription refills or regarding billing matters. Please list all individuals by name that we are authorized to speak with about these matters, including a spouse.

Please be sure to list authorized individuals *by name* and not by relationship to the patient, such as "nanny". The patient, parent or legal guardian must sign the authorization. Once authorization is given, it may be revoked at any time in writing

I authorize HUNTINGTON MEDICAL FOUNDATION to use/disclose my health information as described below. I understand that this authorization is voluntary and that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that a photocopy or facsimile of this authorization is as valid as the original.

Patient Name: _____ _____
Date of Birth: ____/____/____

Person(s) authorized to receive this information:

_____

_____

_____

Information that may be used or disclosed:

- ☐ Record of visits (specify dates)
- ☐ Record of visits (all)
- ☐ Discharge summary
- ☐ History/Physical
- ☐ Consultation Report(s)
- ☐ Operative Report(s)
- ☐ Problem List
- ☐ Progress Notes
- ☐ Immunization Records
- ☐ Medication Records
- ☐ Laboratory Reports
- ☐ X-Ray, MRI, CT Reports
- ☐ Echo, Stress Tests, Holter Monitor Tests
- ☐ EKG Report(s)
- ☐ Mental health/Alcohol/Drug Abuse Treatment
- ☐ AIDS or HIV Information
- ☐ Hepatitis Information
- ☐ Entire Medical record
- ☐ Billing Record(s)
- ☐ Other (specify)

I understand that I may revoke this authorization at any time by notifying Huntington Medical Foundation in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires on ____/____/____.

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

_____ ____/____/____
SIGNATURE OF PATIENT OR REPRESENTATIVE TODAY'S DATE

_____
PRINTED NAME OF PATIENT'S REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT

THIS AUTHORIZATION IS H.I.P.A.A. COMPLIANT
REVISED 09.04.03