AUTHORIZATIONFORDISCLOSURE OF MEDICAL RECORDS

In accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder governing the privacy of health information, thisnotice informs you of the purpose of the form and how it will be used.
PRINCIPAL PURPOSE(S):This form is to provide **Santé Plus Medical Center** with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S):To any third party or the individual upon authorization for the disclosure from the individual, within 3 to 5 BUSINESS days, for: personal use; insurance; treatment or continued medical care; school; legal; retirement/separation; or other reasons as specified below.
DISCLOSURE:Voluntary. Failure to sign the authorization form will result in the non-release of the medical records.

Client Name: ____________________ **DOB:** ____________________

☐ Iam the client and hereby authorize the use or disclosure of health information, including protected health information, about me as described below.
☐ I am the client's representative and understand and agree to the provisions of this authorization on behalf of the client. My authority to act on behalf of the client is as **follows:** ____________________

By signing this form, I authorize the release of health information, including protected health information. I authorize Sanitas to:

☐ **disclose to**	☐ **obtain from**
Please enter Providername & contact information ____________________	Please enter Provider name & contact information ____________________

INFORMATION MAY BE DISCLOSED BY: Santé Plus Medical Center and any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

INFORMATION TO BE DISCLOSED: (Initial Selection)

________General Medical Record(s), including TB ________Progress Notes ________ Consultations ________ History and Physical Results
________Immunizations ________ Family Planning ________ Prenatal Records ________ Diagnostic Test Reports

Specify Type of test(s):____________________

________Other: ____________________ Specify dates of service:____________________

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the disclosure of the type of highly confidential information indicated next to my signature.

☐ DNA/Genetic Testing ____________________
☐ Mental Health Records ____________________
☐ Sexual Assault ____________________
☐ Sexually Transmitted Disease ____________________
☐ Alcohol/Substance Abuse Service Provider Client Records____________________
☐ Psychologist/Psychotherapeutic Notes and Records____________________
☐ Marriage/Family Therapist or Clinical Social Worker Records____________________
☐ Child Abuse or Neglect/Early Intervention____________________
☐ Confidential HIV-Related Health Information____________________

PURPOSE OF DISCLOSURE:

☐ Treatment ☐ Personal Use ☐ Billing/Payment ☐ Continuity of Care ☐ Other (specify) ____________________

EXPIRATION DATE: This authorization will expire (insert date or event)____________________ . I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.
REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
CONDITIONING: I understand that completing this authorization form is voluntary and that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.
REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.
FEES FOR COPIES: I understand that federal and state laws permit certain fees to be charged for the copying of patient records and that I may be charged fees in accordance with such laws.

I request and authorize the disclosure of information described above.

Patient/Guardian/Caregiver Signature ____________________ Date ____________________

Printed Name Patient/Guardian/Caregiver____________________ Relationship to Client ____________________

Witness (optional) ____________________ Date ____________________