



AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT CLEARLY

MR# _____

Patient Name _____
LAST FIRST INITIAL

Address _____
STREET CITY STATE ZIP

Phone (____) _____ Date of Birth _____ Medical Record # _____

1. I authorize the use or disclosure of the above named individual's health information as described below. _____

2. I hereby authorize: _____

The information to be released is limited to the following:

- Entire Record
- Specific Information:
- Old Records from Previous Physicians

3. I give special permission to release any information regarding: (initial on line(s) below that you grant us permission to release the information to the above)

- Substance Abuse
- Psychiatric/Mental Health Information
- HIV Information

4. Furnish records to: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management 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 when the law provides my insurer with the right to contest a claim under my policy.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

7. This authorization will automatically expire six months from the date signed, unless otherwise indicated.

8. I understand that the requestor may not further use or disclose protected health care information unless another authorization is obtained, or unless law specifically requires such disclosure.

The law permits the use or disclosure of protected health care information without authorization for the purpose of coordinating a treatment plan, payment for services, and or to evaluate the quality of care you receive.

Pioneer Medical Group may also disclose your protected health care information for the purpose of research, public health, auditing, law enforcement, and emergencies. We are required by law to provide medical information that is court ordered and or requested by law enforcement officials.

Patient Access to Records Fee: *The Privacy Rule permits the covered entity to impose reasonable, cost-based fees. The fee may include the cost of copying (including supplies and labor) and postage, if the patient requests that the copy be mailed. If the patient has agreed to receive a summary or explanation of his or her protected health information, the covered entity may also charge a fee for preparation of the summary or explanation. (45 CFR 164.524)*

Signature of Patient or Legal Representative _____ Date _____

If not patient, state relationship _____

Signature of Witness _____ Date _____