AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW

Patient Name:

Patient Date of Birth: Patient's SSN:

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) or Organization(s) authorized to receive the information:

C. Purpose of Request – please check all that apply

☐ **Treatment or consultation** ☐ **Request of the patient** ☐ **Billing or claims payment**

☐ **Other (specify)**____

D. Please check type of information to be release: ☐ **Paper** ☐ **Electronic CD-ROM**

Covering the Period of Health Care from (date)______________ **to** ________________

☐ **Entire Medical Record** ☐ **Pathology Reports** ☐ **Labs**

☐ **Progress Notes** ☐ **X-Ray** ☐ **Immunizations**

☐ **Other (specify):**____

Drug and /or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release.

Check one: ☐ Yes ☐ No Initials________

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check one: ☐ Yes ☐ No Initials________

1) I understand that this authorization will **expire** on ____________. If a date is not indicated, authorization will expire in 90 days.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *Berryville Medical Associates PLC.* in writing.
3) I understand I may be charged a fee of $.50 for each page up to 50 pages and $0.25 for each additional page. There will also be a $10.00 process and handling fee required for paper or CD-ROM and if copies are to be mailed postage will also be charged.
4) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
5) I may **inspect or copy** any information used or disclosed under this agreement.
6) I understand that if the person or organization that receives the information is covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

______________________________ ______________________

Patient Signature or Patient Representative Date

______________________________ ______________________

Printed name of Patient or Representative Relationship to Patient

______________________________ ______________________

Signature of Witness Date

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signatures ☐ Other, specify______________

Name, Date, and Title of Person Who Released Records:_________________________________