

# Post Falls Family Medicine, PA

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## Authorization to Receive Medical Information

Patient Name (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

RECEIVE RECORDS FROM :

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Information to be released: (if not clearly defined, the most recent 2 years will be released)

- History & Physical Date: \_\_\_\_/\_\_\_\_ (mm/yyyy)
- Immunizations
- Post Op Report Date: \_\_\_\_/\_\_\_\_ (mm/yyyy)

Most Recent:

- Lab
- X-Ray
- Office Visit
- Other Information (Please specify) \_\_\_\_\_

Purpose for which disclosure is being made: (please check one of the following)

\_\_\_\_ Attorney \_\_\_\_ Insurance \_\_\_\_ Doctor \_\_\_\_ Personal \_\_\_\_ Other \_\_\_\_\_

EXCLUDE the following information from the records released (please initial):

\_\_\_\_ Drug/Alcohol abuse/Treatment and diagnosis      \_\_\_\_ Sexually transmitted disease  
\_\_\_\_ Mental Illness or psychiatric diagnosis and treatment      \_\_\_\_ HIV/AIDS

### MY RIGHTS:

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by the HIPAA regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed with this authorization. There may be a charge for these copies.

This authorization will automatically expire six months from the date signed or until the 3rd party payer claim is secured. I understand that I may revoke this authorization any time except to the extent that action has been taken in relationship thereon. To revoke this authorization I must submit my request in writing to Post Falls Family Medicine, P.A.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient, Guardian\*, or authorized representative\*)

\*Please provide documents to prove authority to sign on behalf of the patient.

Possible copying fee required