

AUTHORIZATION TO RECEIVE / DISCLOSE PROTECTED HEALTH INFORMATION

▪
Patient Name

▪
Date of Birth

▪
Patient Address

▪
City / State / Zip

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION FROM:

Name of Person or Organization Releasing Information	
Address of Person / Organization	
Phone Number	Fax Number

TO RELEASE MY INFORMATION TO:

Name of Person or Organization Receiving Information	
Address of Person / Organization	
Phone Number	Fax Number
Email Address:	
Sent Via: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Email Address (<i>Sent via <u>encrypted email</u> unless requested otherwise</i>)	
<i>*Please note if PHI (Personal Health Information) is sent using unencrypted email the information is at risk for interception by an unknown party while in transit*</i>	

INFORMATION TO BE RELEASED:

<input type="checkbox"/> Complete Medical Record
<input type="checkbox"/> Medical Records from Specific Dates of Service (<i>Please list</i>): From: _____ To: _____
<input type="checkbox"/> Other (<i>Please list</i>): _____

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to disclosure and may no longer be protected by federal state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA). I understand that I have the right to inspect a copy of protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization will remain in effect for one calendar year from the date of completion in accordance to the data contained herein.

▪
Signature of Patient or Representative

▪
Date

▪
Description of Representative's Authority (ATTACH DOCUMENTS IF APPLICABLE)

BELOW FOR OFFICE USE ONLY

Received By:	Date:	Via:
Sent By:	Date:	Via:

Tina Rutar, M.D.

Justin Spaulding, D.O.

Allison Jarstad, D.O.