TOTALCARE
Family Medicine | Urgent Care

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

**I hereby authorize the use or disclosure of information from the medical record of:**

Patient Name_____

Date of Birth_____ Social Security #_____ (optional)

**I authorize TotalCare to disclose the above named individual's private health information.**

**This information may be disclosed TO and used by the following individual or organization:**

*Facility or Individual's Name_____ Address_____

City, State, Zip_____ Phone_____ Fax_____

**For the purpose of: _____**

**Please release the following:**

_____Entire Record

**or:**

___Problem List

___Progress Notes

___History/Physical Exam

___Medication List

___Immunization Record

___List of Allergies

___Billing records: from (date) _____ to (date) _____

___X-Ray/Imaging Reports: from (date) _____ to (date) _____

___X-Ray films

___Laboratory Results: from (date) _____ to (date) _____

___EKG Reports

___Genetic Testing Information

___Other Diagnostic Reports (Specify) _____

___Other (Specify) _____

*I understand that the information in my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.*

_____***Yes**, I consent to the release of this information.* _____***No**, I do not consent to the release of this information.*

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

*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 individual or organization releasing information. I understand that the revocation will not apply to information already 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. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.*

***PLEASE COMPLETE PAGE TWO OF THIS FORM***

TOTALCARE
Family Medicine | Urgent Care

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in the CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact TotalCare Medical Records Department.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

**Cost of Copies:**
$14.00 (pages 1-25)
$4.00 Each additional 10 pages
$5.00 per USB additional USB drive
Postage costs if applicable

| **COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT** | |
|---|---|
| ***I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold TotalCare liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.*** | |
| _____ | _____ |
| **Signature of Patient or Legal Representative** | **Date** |
| _____ | _____ |
| **Relationship to Patient (If Legal Representative)** | **Witness** |

I request that TotalCare provide me with a copy of my protected health information in the following form or format:

☐ PDF ☐ Paper

How would you like to receive your information?

☐ CD ☐ USB ☐ Fax Fax Number: _____

☐ Email Email Address: _____

Please Print Clearly (If we cannot read your email address, we will not send your records.)

**Please be advised that our email is not encrypted and may therefore be at risk of being accessible by unauthorized individuals. By checking the box below, you are acknowledging that you have been made aware of these risks and give your permission for this office to email your protected health information to the email address you have provided above.**

**☐ I acknowledge that I have been notified of the risk of unencrypted email.**

Date Received by Records Department:_____ Reviewed by:_____ Request Received by:_____

Date Request Completed: _____ #of pages copied: _____ Charges: $_____