Authorization to Obtain or Disclose Protected Health Information

This form must be complete in order for request to be fulfilled

Patient name:____ Date of birth: ____________________

Previous name (if applicable):_____________________________________ Last 4 digits of SSN:_______________

University ID: ____ Phone:_______________________

MEDICAL	COUNSELING
☐ <u>ALL</u> my health information	☐ Progress Notes
☐ <u>ONLY</u> my health information as specified below	☐ Testing Summary
☐ Chart Notes	☐ Summary Letter
☐ Immunizations	☐ AODA Information
☐ Lab Results	☐ Other:_____________________________
☐ Sexual Health (Gyn, STI Tests &Treatment)	
☐ Medical Mental Health Evaluation & Treatment	
☐ Other:________________________________	

Select One: ☐ **Disclose Health Information *TO*** Holistic Care and Recovery, Inc ☐ **Request Health Information *FROM***

315 Doris Drive
Lakeland, FL 33813

Name (or title) and organization: ____

Address: ____ City:___________________________

State: __________ Zip:______________ Phone:__________________________ Fax:___________________________

This authorization is valid until date specified or 1 year unless revoked in writing:

☐ Other date of expiration (if desired): _________________________________

This information for which I'm authorizing disclosure will be used for the following purpose:

☐ My personal records ☐ Sharing with other health care providers ☐ Other (please describe)___________________________________

<u>My Rights</u>

I understand that when I revoke this authorization, it is not effective to the extent that UHS has already relied on the use or disclosure of the protected health information. I understand the protected health information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. UHS will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. I understand that I have a right to refuse to sign this authorization. To revoke this authorization, please submit a request in writing to the UHS privacy officer. If you have any questions concerning this form, please phone (208) 426-1459.

Specific Authorization: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have indicated otherwise.

Patient Signature ____ Date of Request ____________________

Office Use Only

_______________ Date Completed ___________________________ By (print name) ☐ Mailed ☐ Faxed ☐ Patient Pick Up ☐ Other:_________________

Holistic Care & Recovery

315 Doris Drive

Lakeland, FL 33813

Revised March 2014 MMD