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Release of Patient Health Information

Patient's Full Name: _____ Date of Birth: _____
Maiden/Other Names: _____

I hereby authorize Upstream Family Medicine to (please initial): _____ Obtain records from: _____ Release records to:
Name: _____ Phone: _____
Address: _____ Fax: _____

- Information to be released: For the purpose of: Dates of service:
All Records (including those listed below)
Demographic Information
Progress Notes
Lab Reports
Radiology Reports
Psychiatric/Mental Health
Other (list)
Further Medical Treatment
Payment of Claim
Legal Request
Personal
Other (list)
to _____

I acknowledge that the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to Upstream Family Medicine. I understand that the revocation will not apply to information that has already been released in response to this authorization, and 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. In absence of a revocation, this specific authorization expires on _____. (If left blank, will expire one (1) year from date of my signature.) Maximum for authorization is one (1) year from date of signature.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

Patient or Legal Representative Signature _____ Date _____ Witness _____

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, and, 2) mental health conditions, and 3) drug and alcohol abuse diagnosis or treatment (this information is subject to Federal Regulation 42 CFR Part 2). I specifically authorize Upstream Family Medicine to release health information checked below:

- Reproductive Care
Sexually Transmitted Diseases (including HIV/AIDS)
Mental Health/Illness
Drug/Alcohol Abuse

Patient or Legal Representative Signature _____ Printed Name _____ Relationship to Patient _____

Phone _____ Date Signed _____ Witness _____