Mahube-Otwa Family Health
AUTHORIZATION FORM FOR RELEASE OF INFORMATION

Patient Name:	Last	First	MI	Maiden/Other Name	Patient #:
Date of Birth: Mo/Day/Year		**Day Phone:** (Contact OK Y / N)		**Evening Phone:** (Contact OK Y / N)	

1. Authorization:

I authorize

Name: (person or clinic)	
Address:City/State/Zip	
Phone:	
Fax:	

to use and disclose the protected health information described below to:

Name: (person or clinic)	
Address:City/State/Zip	
Phone:	
Fax:	

2. Effective Period

This authorization for release of information covers the period of healthcare from:

☐ _____ to _____

or

☐ all past, present, and future periods

3. Extent of authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatments
- ☐ Other (please specify): _____

CONDITIONS OF AUTHORIZATION

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposed as I may direct.
2. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. Mahube-Otwa Family Health will not penalize me if I do not sign this authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
7. I have been offered a copy of this signed authorization form.

Your health is important to us. If you have any questions or concerns, please call your Family Health Clinic location or 877-275-6123.

_____ **Date:** _____
Patient Signature or personal representative

_____ **Date:** _____
Printed name of patient or personal representative and his/her relationship to patient

_____ **Date:** _____
Staff Signature

Patient Identity confirmed by (Picture I.D./Signature/SS#): _____