

Family First Medicine

1140 Charles Lane Marysville, Ohio 43040

937-578-4291 (P) 937-578-4294 (F)

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: (physician or facility transferring from): _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records

_____ Lab results/X-ray reports

_____ Physical exam

_____ Consultation reports

_____ Immunization record

_____ Other (please specify): _____

4. I understand that the information in my health record may include information relating 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.
5. This information may be disclosed to and used by the following individual or organization.

Name: Family First Medicine, Dr. Anna Clem-Badhwar D.O.

Address: 1140 Charles Lane

City: Marysville State: Oh Zip: 43040

For the purpose of: _____

6. 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 health information management department. 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 will expire on the following date, event, or condition: _____ .
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. 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 assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 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.

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- Day-to-day health care operations of the practice.

I have also been informed of, and given the right to review and secure a copy of your Statement of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry our treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Exceptions to Protected Health Information

I wish to be contacted in the following manner (check all that apply)

Home Telephone #

- Ok to leave message with detailed information
- Leave message with call-back number only

Work Telephone #

- Ok to leave message with detailed information
- Leave message with call-back number only

Cell Phone #

- Ok to leave message with detailed information
- Leave message with call-back number only

Email Address

@

- Ok to send message with detailed information

I authorize the release of medical information to the following people:

Patient Signature and Date