

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____
(Name of physician or health care provider authorized to use or disclose information)

To furnish to Acclamation Insurance Management Services or _____
(Name and address of person/organization to which disclosure is made)

Health information described below on: _____
(Patient name)

For the purpose of: _____
This information is limited to the following type and amount of information. (Use dates where appropriate.)

Progress Notes	Immunization Records
Consultation Reports	Any and all Records for the last 2 years
Laboratory, Pathology Reports	from _____ to _____
Radiology Reports/Imaging Reports	from _____ to _____
Medical Records relating to injury	(date) _____
Other: _____	

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health care information relating to the testing, diagnosis or treatment for: (initial appropriate area)

HIV/AIDS virus _____
Sexually Transmitted Diseases _____

Mental Health/Psychiatric Disorders _____
Drug, Alcohol Abuse/Treatment _____

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been 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 will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months from date of signature.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. 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 redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

A carbon copy, photo static copy or fax copy of this true release shall be as valid as the original.

Signature of Patient, Parent or Legal Guardian

Patient Date of Birth

If signed by other than patient, indicate relationship

Patient Address

Patient telephone number

Patient Social Security Number

Witness signature

Date