Authorization to Use/Disclose Health Care Information

Patient Name: _____
Date of Birth: _____

I request and authorize _____
to release the health care information described below to:

Name: _____
Address: _____
City, State: _____ **Zip Code:** _____
Phone: _____ **Fax:** _____

Please check to specifically authorize the use and/or disclosure of:

____Emergency Room/Urgent Care Records
____Hospital Records (nursing and progress notes)
____Initial Psychiatric Evaluation
____Medication History
____Outpatient Progress Notes
____Billing Statement
____Consultation Report (specify): _____
____Admission Note
____Discharge Summary
____Clinical Summary
____Psychological Test Reports
____Verbal Discussion of Case
____ Other: _____
____Lab reports:_____

The requested records or information is about health care provided during the following approximate time frame: _____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Anne Tyson, M.D.

I understand the Dr. Tyson may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to Anne Tyson, M.D. from a third party.

I understand that my express consent is required to release any health care information relating to testing , diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use .

Signature (patient or authorized representative): _____
Date: _____
Relationship/authority (if signed by authorized representative): _____

Authorization expires one year from date signed.
I have received a copy of this signed authorization: (please initial) ____yes ____no