

JORDAN PHYSICIAN ASSOCIATES

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize (practice name) _____, at address: _____
 _____ to use or disclose the following health information from the
 medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be
 subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient Name:** _____ **Date of Birth:** ____/____/____ **Phone #:** _____
 Address: _____

Street
City
State
Zip

3. **Information to be disclosed to:** _____
 Address: _____

Street
City
State
Zip

4. **Disclose the following information for treatment dates:** ____/____/____ to ____/____/____:

- Abstract** (i.e. - History & Physical, Operative/Procedure Reports, Clinic Notes, Discharge Summary, Diagnostic Test Results, Emergency Room Reports)
- Consultations Diagnostic Imaging Discharge Summary Emergency Reports
- History & Physical Laboratory Reports Operative Notes Outpatient Reports
- Pathology Reports Progress Notes Therapy X-Ray/X-Ray Reports (specify below)
- Other (specify) _____
- Entire Medical Record (additional time and copying fees may apply)

5. The above information is disclosed for the following purpose: Medical Care Legal Insurance Personal

6. The means of delivery of the above information shall be:
 In person Mail Fax to: (____) _____ E-mail to: _____@_____ Other _____

7. In what format do you want the information? Paper USB CD

8. I understand I may **revoke this authorization** at any time by requesting such of the above-referenced hospital, physician, or facility, in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization **expires** after ninety (90) days from the date I signed it unless otherwise specified.

 Signature of Patient or Legal Representative

_____/_____/_____
 Date

 Printed name of Patient or Legal Representative

 Relationship to Patient/Authority to Act for patient (attach documentation)

9. I understand that my record may contain information in reference to treatment for Substance Abuse and/or Alcohol Abuse, Psychiatric treatment, Sexually Transmitted Diseases, Social Service notes, HIV/AIDS, Genetic Testing or other sensitive information. I agree to its release unless otherwise specified (please explain).

 Signature of Patient or Legal Representative

_____/_____/_____
 Date

 Printed name of Patient or Legal Representative

 Relationship to Patient/Authority to Act for patient (attach documentation)