MEA Medical Clinics
a service of St. Dominic's

MEA PATIENT ACCT. NO

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, MEA Medical Clinics may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I, _____ understand that the information contained in my record is
(name of patient)

confidential. However, I give my consent for _____ at
(name of physician)

_____ to release my
(physician address)

treatment records from _____ to _____, or information concerning such records to:
(date) (date)

_____
(specific physician or organization)

_____
(address)

for the specific purpose of _____
(specific nature and extent of information to be released)

I understand that the document authorized to be released by me include, but are not limited to, family histories, reports of clinical findings and diagnosis, laboratory test results, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon _____ (not to exceed six months) and cannot be renewed without my written consent.

_____ _____
Signature of Patient Date

_____ _____
Signature of MEA Personnel (Witness) Date

_____ _____
Signature of Physician Date

PATIENT IDENTIFYING DATA

_____
(Last Name) (First Name) (MI) (Maiden Name)

_____
(Address)

_____
(Date of Birth) (Social Security Number)

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MEA may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.