MEA PRIMARY CARE PLUS

Authorization for Release of Protected Health Information (PHI)

Patient's Name:	Birth Date:	Patient's Address: (city, state, zip)
Patient's Phone Number:	Patient's Email Address:	Last 4 Digits of Social Security Number:
Requester's Name:	Requestor's Relationship to Patient:	

Purpose of Disclosure

❑ Medical Care ❑ Legal ❑ Insurance ❑ Personal ❑ Other

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes?

❑ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

❑ No, then you may check as many items below as you need.

Information to be disclosed:

❑ After Visit Summary (AVS) ❑ History & Physical Exam ❑ Operative Report ❑ Itemized Bill

❑ Laboratory Report ❑ Radiology Report ❑ Consultation

❑ Pathology Report ❑ EKG ❑ Other: _____

Date of Service: _____to_____ Date of Service: _____to_____ Date of Service: _____to_____

The following information will be released when included in the above unless you indicate otherwise:

❑ Do not release any AIDS or HIV test results ❑ Do not release any records of psychiatric care

❑ Do not release any records of alcohol/drug abuse ❑ Do not release records of genetic testing

Individual or Entity Authorized to **DISCLOSE** Information:	Individual or Entity Authorized to **RECEIVE** Information:
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

1. I understand that this authorization is voluntary and that I may refuse to sign per the Health Insurance Portability and Accountability Act (HIPAA).
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Legal Representative:	Date:	Time:
Print Name of Patient or Legal Representative:	Relationship to Patient or Legal Representative:	

This authorization shall expire on this expiration date: _____

** If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed. **