MEDICAL INTERVENTIONS
265 W. SR 50, CLERMONT, FL 34711
P. (352) 394-5535 • F. (352) 394-5810

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

Name of Patient:_____ **D.O.B.:**_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **MEDICAL INTERVENTIONS** to release to_____

PHONE:_____ FAX:_____

(Person(s) / Organizations authorized to receive the information) (Address: street, city, state, zip)

The following information:

Only the following records or types of health information pertaining to my medical history, mental or physical condition and treatment received

☐ **ONE (1) YEAR TO PRESENT OF LAB RESULTS, DIAGNOSTIC TESTS, EVALUATION REPORTS AND PROGRESS NOTES INCLUDING CURRENT MEDICATION LIST AND PSYCHOTHERAPY NOTES[1], HIV TEST RESULTS, AND/OR ALCOHOL/DRUG TREATMENT INFORMATION.**

☐: OTHER: _____

PURPOSE OF USE/DISCLOSURE: ☐Patient request; ☐PCP request; **OR** ☐Other _____

EXPIRATION This Authorization expires on: 1 YEAR FROM DATE SIGNED
(Date)

MY RIGHTS I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2] I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **265 W. Hwy. 50, Clermont, FL 34711.** My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization.[3]

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by state law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE_____ Date_____ Time_____ am/pm
(Circle one: patient / representative / spouse / financially responsible party)

If other than patient, legal relationship:_____ Witness_____

[1]If mental health information covered by the Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the Physician, licensed psychologist, social worker with a master's degree in social work, or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record him/herself and then provide the records to the third party, however.

[2]If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrolment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrolment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a healthy plan's eligibility or enrolment determinations relating to the individual of for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3]Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures.