AUTHORIZATION TO RELEASE INFORMATION

Patient name: ____

Any Other Previous Names: ___________________________ Date of Birth: ________________________
Address: ____ Phone Number: ______________________
City: ________________________ State: ____ Zip: _________ Email: ______________________________

I hereby authorize CareMedica to:
Please choose one: ___Release my medical information to: ___Obtain medical information from:
Name/Facility: _______________________________ Attention: _____________________________________
Address: ____________________________________ Phone Number: _______________________________
City: ________________________ State: ____ Zip: _________ Fax Number: _________________________
Purpose of request: ___Personal ___Referral or 2nd option ___Legal ___Insurance
Other: ______________________
Workers Comp (only) Date of Injury ____________ Body Part Tested _______________

Specific Records/Report(s) to be released: (allow 7-10 days for turnaround of request)
Date of Service: _________________________
___Consultation/Progress Reports ___Radiology Reports ___Labs ___Physical Therapy Notes
___All Immunizations ___Med List ___Problem List ___Bills
___Other: ______________________________
___Enter Record (ONLY when subsections of the record will not serve the intended purpose of the disclosure)

Restricted Authorization to Release Protected Information:
IMPORTANT – you must select either "DO" or "DO NOT" for each item contained in this section. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.
I ___ DO ___ DO NOT want Mental/Behavior Health or Disability Services Provider Documentation* released.
I ___ DO ___ DO NOT want HIV/AIDS Screening Test Results released.
I ___ DO ___ DO NOT want information about Alcohol and/or Substance Abuse Treatment *** released.
I ___ DO ___ DO NOT want Genetic Testing/Test Results ** released.
I ___ DO ___ DO NOT want Confidential Communications with a Social Worker released.
I ___ DO ___ DO NOT want information about Rape/Sexual Assault Victim's Counseling released.
I ___ DO ___ DO NOT want Child/Elder Abuse or Neglect & Abuse of an adult with a Disability released.
I ___ DO ___ DO NOT want information about Sexually Transmitted Diseases (STD's) released.
I ___ DO ___ DO NOT want information about Domestic Violence Victims Counseling released.

*This authorization is not valid for use or disclosure of psychotherapy notes
**The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.
***Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical Facility.

I understand the following:

1. I may revoke this authorization at any time by providing written notice to the practice.
2. I may not be able to revoke this information if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance information.
3. The practice will not condition treatment or payment based on my signing of this authorization.
4. I am signing this authorization freely.
5. No one has pressured me to sign this authorization.
6. The information disclosed in this authorization for may be subject to re-disclosure by the practice and no longer protected by federal law.
7. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
8. I have received a copy of this authorization.

____ _____________________

Patient's Signature Date

_________________________________ _______________ _____________________

Signature of Personal Representative Date Relationship to Patient

PAPER RECORDS ONLY