



HIGHLAND CLINIC
A Professional Medical Corporation

Authorization to Disclose Health Information

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that Highland Clinic, APMC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized permission, except as required by law.

Patient Name: _____
Last Name First Name Middle Initial

Patient Address: _____
Street City State Zip Code

Home Phone: () _____ **Date of Birth:** _____ **SSN:** _____

I authorize _____
Name of the Physician and/or Facility Mailing Address City, State, Zip

To release to _____
Name of the Physician, Facility, Other, or Self Mailing Address City, State, Zip

The following specified information: (Place a mark in the box and specify any dates in the blank line provided.)

- Entire Record: _____ Progress Notes: _____
- Lab: _____ Correspondence: _____
- X-ray: _____ Records from other facilities: _____
- Other : _____

Purpose for disclosure: Medical Care Legal Insurance Personal Other _____

I authorize the disclosure of the information described above via: Copy Fax Verbal Written

READ THE FOLLOWING CAREFULLY BEFORE SIGNING

By signing this form, I understand that I am authorizing the release or disclosure of the requested health information as marked above in accordance with any specifications I have made. I also understand that the health information to be released may include reference to treatment or history of: 1)Mental or behavioral health, 2)Alcohol or drug abuse, 3)HIV and/or AIDS.

****INITIAL IN THE SPACE PROVIDED IF YOU DO NOT AUTHORIZE THE RELEASE OR DISCLOSURE OF THIS INFORMATION.** _____

- This authorization will expire one (1) year from the date it is signed by the patient or legal representative.
- The patient or legal representative may revoke this consent at any time with written request.
- Any health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highland Clinic, APMC, or the federal privacy regulations.

Patient or Legal Representative Signature Date Signed

Witness Signature (Only for a Legal Representative) Date Signed

<p>Office Use Only</p> <p>Date form received: _____</p> <p>Date request completed: _____</p> <p>Clerk Initials: _____</p>
