HIGHLAND CLINIC

A Professional Medical Corporation

Authorization to Disclose Health Information

Revision Date: October 2018

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:** _____

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

_____ _____
Fax Number Phone Number

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

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

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.***
********I**NITIAL 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

Office Use Only
Payment received: ☐Yes ☐No Payment made via: ☐Cash ☐Check ☐Charge
of the Receipt given for payment received: _____
Date form received: _____
Date request completed: _____
Clerk Initials: _____