

Authorization to Disclose Health or Billing Information

PATIENT INFORMATION	Medical Record # _____	Date of Birth _____
Patient Name _____		Patient Address _____
Patient Nickname/Maiden Name _____		
I give permission to:		To release information to:
Name of Person/Facility _____		Name of Person/Facility Address _____
City/State/Zip _____		City/State/Zip _____
Phone # _____	Fax # _____	Phone # _____ Fax # _____
Check information to release		
<input type="checkbox"/> Name	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Nurses Notes
<input type="checkbox"/> Address	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Phone Number	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Medication Records
<input type="checkbox"/> Insurance	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Social Security #	<input type="checkbox"/> Consultation	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Other (Describe) _____	
Treatment Dates (If certain dates are wanted) _____		

This is a full release including all drug, alcohol, psychiatric and sexually transmitted disease information unless listed here:

Check reason for release <input type="checkbox"/> Patient Request <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Treatment <input type="checkbox"/> Insurance <input type="checkbox"/> Other (Describe) _____
Release Information <input type="checkbox"/> In Person <input type="checkbox"/> Pick up <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other (Describe) _____

1. By law, Batish Family Medicine can't use or share my health information without my permission except by ways listed in Batish Family Medicine's notice of Privacy Policies.

2. I can cancel this authorization at any time. I must cancel in writing and address it to the person or organization named above. I can't cancel consent for information already shared as a result of this permission.

3. I don't have to sign this form. Refusal won't change my ability to get treatment, payment for treatment or benefits.

4. Once information is sent, it may not be protected by law and someone may be able to share my information with others without my permission.

5. I have read, understand and been given a copy of this form.

6. This is not for use for Marketing or Research.

NOTICE: I may be charged to copy or mail this information.

Authorization expires 90 days after I sign it unless a date or event is written here: _____

Patient/Patient Representative Signature _____	Date _____
Legal Authority to sign for patient: <input type="checkbox"/> Guardian <input type="checkbox"/> Administrator/Executor <input type="checkbox"/> Attorney in Fact <input type="checkbox"/> Parent <input type="checkbox"/> Next of Kin <input type="checkbox"/> Other (Specify) _____	
Patient is <input type="checkbox"/> Minor <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased <input type="checkbox"/> Incompetent <input type="checkbox"/> Incapacitated	
If limited English proficient or hearing impaired, offer interpreter at no extra cost: Interpreter: <input type="checkbox"/> Accepted <input type="checkbox"/> Refused _____ <div style="text-align: center; font-size: small;">(Name/Number of Person/Services Chosen/Used)</div>	