AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
SIH Medical Group

PATIENT INFORMATION

____ _____/_____/_____ __________

First Name MI Last Name Maiden Name Date of Birth Last 4 SS#

Purpose of Disclosure: ☐ Request of Patient ☐ Healthcare Treatment/Service ☐ Insurance ☐ Other: ____________________

I authorize (name of SIH MG Provider/Clinic): ____
to disclose the below medical information to:

____

Name Street Address City State Zip

Specific information to be disclosed (check all that apply) Date(s) of Treatment: ____________________

☐ Office Visit Note	☐ Immunization Record	☐ Consultation Report	☐ Laboratory Reports	☐ Itemized Bills
☐ Physical	☐ Pathology Report	☐ Radiology Report	☐ Operative Report	☐ Other:

Your medical and billing information may include sensitive information including but not limited to the examination, diagnosis, evaluation, treatment and or rehabilitation pertaining to a) alcohol and/or substance abuse, b) HIV/Aids, c) mental/behavioral health, d) development disability, e) sexually transmitted disease (STD); f) reproductive health.

I authorize disclosure of my sensitive information (check all that apply):

☐ Alcohol and/or Drug Abuse	☐ HIV/Aids	☐ Mental/Behavioral Health*	☐ Developmental Disability	☐ Sexually Transmitted Disease	☐ Reproductive Health

I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand the revocation will not apply to information already released in response to this authorization.

This authorization will expire on ____/______/______ (*date is required for disclosure of mental/behavioral health information). If I do not specify an expiration date and the health information disclosed does not include mental/ behavioral health information, I acknowledge this authorization is valid for 6 months from the date of my signature.

I understand the information (excluding mental health information, developmental disability, alcohol and substance abuse information, and/or HIV/Aids information) being disclosed under this authorization, may be subject to redisclosure by the recipient and no longer protected under the Health Insurance Portability and Accountability Act (HIPAA).

I understand authorizing the disclosure of the health information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I agree a photocopy of this authorization is valid as the original.

Patients 12-17 years of age have authority to authorize disclosures for information pertaining to mental health and developmental disability, alcohol/drug abuse, HIV/Aids, STD's, reproductive health (abortion), criminal sexual assault or abuse.

____ ____________________

Signature Patient/Patient's Legal Representative Date

Check one:

☐ I am the patient

☐ I am the Legal Representative of the Patient (complete a & b)

a) ____

First Name Last Name Phone Number

b) Relationship to Patient: ☐ Parent ☐ Guardian ☐ Legal Representative/Agent.

Witness Signature (required for disclosure for mental health and developmental disabilities)

____ Date: ________________

Witness Printed Name

____

First Name MI Last Name