Holmes Family Medicine, Inc.

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:* ***(example doctor, hospital, transferring facility, etc)***

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Professional relation to patient: (doctor, hospital, etc.): _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records _____ Lab results/X-ray reports

_____ Physical exam _____ Consultation reports

_____ Immunization record

_____ Other (please specify):_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____initials

5. *This information may be disclosed to and used by the following individual or organization.*

HOLMES FAMILY MEDICINE, INC.
151 Parkview Drive
Millersburg OH 44654
Phone: 330-674-1200 Fax: 330-674-3320

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ .
7. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Scott Brown, M.D., Privacy Officer for Holmes Family Medicine, Inc.

_____ _____

Signature of patient or legal representative Signature of witness

Date:_____ Date: _____