Center for Prevention and Treatment of Infections

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Authorization to Release Confidential Information

I, ________________________________(name) _________________ (date of birth) HEREBY AUTHORIZE The Center for Prevention and Treatment of Infections, TO RELEASE MY CONFIDENTIAL MEDICAL RECORDS TO:

Person/Facility: ____

Address: ____

Phone #: __________________________   Fax #: ____________________________

INFORMATION TO BE DISCLOSED: (Initial each selection)

_____ General Medical Record(s), including STD and TB   _____ Progress Notes   _____ History and Physical Results

_____ Immunizations   _____ Family Planning   _____   Prenatal Records   _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s)) ____

_____ Other: (specify) ____

I voluntarily authorize and give my permission to allow disclosure of all my health information including any information about sensitive conditions. Records that may be released include all information regarding my health history, hospitalization, tests and outpatient care. This information may relate to sensitive health conditions including, but not limited to: Drug alcohol or substance abuse, Mental health or developmental disabilities (excluding psychotherapy notes), Sickle Cell Anemia, Birth control and family planning, Sexually transmitted disease, HIV/AIDS, tuberculosis, Genetic diseases or tests.

PURPOSE OF DISCLOSURE:

_____ Continuity of Care   _____ Personal Use   _____ Other (specify)____

EXPIRATION DATE: This authorization will expire (insert date or event) _______________. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

____   _____________________________________
Client/Representative Signature   Date

____   _____________________________________
Printed Name   Representative's Relationship to Client

If patient representative is authorized to sign on behalf of the patient by virtue of a legal document, copy said document for placement in patient's medical record.

____   _____________________________________
Signature of Authorized Person Receiving Records   Date

Patient Name:____DOB: _______________________MR #: ______________

Based on DOH 3203,   **Original:** To File   **Copy:** To Client   **Copy:** To Accompany Disclosure