**Unicoi Medical Associates**
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**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**PATIENT:**

_____ _____ _____
Name of Patient/Previous Names | Date of Birth | Phone Number

_____ _____
Street Address | City, State Zip

## AUTHORIZES: RELEASE OF PROTECTED HEALTH INFORMATION

By signing this Authorization Form, I understand that I am giving my authorization of UMA to use and/or disclose my protected health information (PHI) as described in more detail below, to the following person(s) or organization(s):

**TO:**

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State Zip Code

**FROM:**

_____
Name of Health Care Provider/Plan/Other

_____ _____
Street Address

_____
City, State Zip Code

**INFORMATION TO BE RELEASED: ENTIRE RECORD _____, or:**

___Medical History, Examination, Reports ___Surgical Reports ___Immunizations
___Treatment or Tests ___Hospital Records including Reports ___X-Ray Reports
___Allergy Records ___Laboratory Reports ___ Prescriptions
___Consultations
___Other (Specify): _____

For the reasons below which require special permission to release otherwise privileged information, please release records pertaining to:

___Mental Health ___Developmental Disabilities ___Alcoholism
___HIV (AIDS) ___Sexually Transmitted Disease ___ Drug Abuse
____Other (Specify): _____

For the Following Date(s): _____

**PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)**

___Further Medical Care ___Legal Investigation or Action ___Personal
___Insurance Eligibility /Benefits ___Changing Physicians
___Other (Specify): _____

I understand that is the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization, may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

Right to inspect or Copy the Health information to be used or disclosed – I understand I have the right to inspect or copy the health information. I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the office managed, Right to receive a copy of this authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form. Right to Refuse to Sign this Authorization – I understand that I am under no obligation to sing this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. If I am providing authorization for marking purposes, I understand that UMA may receive remuneration from a properly authorized business associates as a result of using or disclosing my PHI. Right to Revoke This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Office Manager. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

**EXPIRATION DATE:** This authorization is good until the following date(s) _____or until the following event occurs:

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**SIGNATURE PATIENT/LEGAL REP**: _____**DATE:** _____