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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Name of Patient/Previous Names Date of Birth

_____ _____
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: **FROM:**

_____ _____
Name of Health Care Provider/Plan/Other Name of Health Care Provider/Plan/Other

_____ _____ _____
Street Address Street Address

_____ _____
City, State Zip Code 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:** _____