HIGHLAND CLINIC
A PROFESSIONAL MEDICAL CORPORATION
A Tradition in Health Care.

Authorization to Disclose Health Information

Revision: April 2003

All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that Highland Clinic, APMC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized permission, except as required by law.

Patient Name: _____

Patient Address: _____

Home Phone: ( ) _____ **Date of Birth:** _____ **SSN:** _____

I authorize: _____
Name of the Physician and/or Facility | Mailing Address | City, State, Zip

To release to: _____
Name of the Physician and/or Facility | Mailing Address | City, State, Zip

The following specified information: (Place a mark in the box and specify any dates in the blanks spaced provided)

- ☐ Entire Record: _____
- ☐ Lab: _____
- ☐ X-Ray: _____
- ☐ Other: _____
- ☐ Progress Notes: _____
- ☐ Correspondence: _____
- ☐ Records from other facilities: _____

Purpose for disclosure: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal
☐ Other _____

I authorize the disclosure of the information described above via: ☐ Copy ☐ Fax ☐ Verbal ☐ Written

READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

By signing this form, I understand that I am authorizing the release or disclosure of the requested health information as marked above in accordance with any specifications I have made. I also understand that the health information to be released may include reference to treatment or history of: **1) Mental or behavioral health, 2) Alcohol or drug abuse, 3) HIV and/or AIDS.**

** INITIAL IN THE SPACE PROVIDED **IF YOU DID NOT AUTHORIZE** THE RELEASE OR DISCLOSURE OF THIS INFORMATION:_____

- This authorization will expire one (1) year from he date it is signed by the patient or legal representative.
- The patient or legal representative may revoke this consent at any time with written request.
- Any health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highland Clinic, APMC, or the federal privacy regulations.

_____ _____
Patient or Legal Representative Signature | Date Signed

_____ _____
Witness Signature (Only for a legal Representative) | Date Signed

OFFICE USE ONLY
Date form received: _____
Date request completed: _____ Clerk Initials: _____