The Physician Network

Patient Authorization for Disclosure of Protected Health Information

I, ____, hereby authorize The Physician Network to disclose my
Patient Legal Name
individually identifiable health information as described below:

I authorize the following person(s) or organization to receive the information:

____ ______________________
Name of person(s) and/or organization *Phone Number*

____ ______________________
Street Address *City* *State* *Zip Code* *Facsimile Number*

For verification purposes, please supply the following information:

Patient's date of birth: _______________ Patient's Social Security Number: _______________

The following information may be disclosed: (please check all that apply)

o All medical records generated from the following treatment date(s): ____________________________

o If only specific medical records, please list: ____

o Entire medical record, because it is the necessary minimum required

o Billing records, please list: ____

o **Special Limitations: Does this authorization exclude (check all that apply);**

 o HIV/AIDS test results (if part of the medical record)

 o Sexually transmitted diseases

 o Other exclusions (must be specific) ____

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Reason for disclosure of the information: ____

This authorization will expire: ____
Expiration date or event (if no date or event provided, authorization will expire in 180 days)

Prohibition on Conditioning of Authorization: I understand The Physician Network will not condition treatment on my signing this authorization, unless I am receiving research-related treatment or the only reason the clinic is providing me with health care is to make a report to a third party, such as my employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

Revocation: I understand that I may revoke this authorization at any time by notifying The Physician Network in writing by sending a letter or a completed Revocation of Authorization form to the manager of the clinic at which I receive health care. I understand that if I revoke this authorization, it will not affect any actions that The Physician Network took before it received my revocation letter. For example, The Physician Network cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the The Physician Network Notice of Privacy Practices. A fax or photo copy of this authorization shall be considered valid as the original

____ ____________________
Signature of patient or personal representative *Date*

Printed name & relationship of personal representative, if applicable:

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