



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____
Address: _____ City & State: _____ Zip Code: _____
Phone Number: _____ SMS PCP (Check): Dr. Gutierrez Krystal Jackson PA-C
Previous Name(s): _____

Provider (who is releasing the information):

Name: _____
Address: _____ City: _____ Zip Code: _____
Phone Number: _____ Medical Record Fax Number: _____

Information to be Released

- Complete Medical Records
- Immunization Records
- Medical Records from (Date) _____ to (Date) _____
- Specific Medical Records _____
- Billing Record(s)- please list _____

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:

- Alcohol, Drug, or Substance Abuse Records (Date) _____ to (Date) _____
- Mental Health Records (Date) _____ to (Date) _____
- HIV/AIDS Test Results
- Sexually Transmitted Diseases

Purpose:

- Transferring Medical Care
- Second Opinion or Specialty Care
- Litigation
- Workman’s Compensation Claim
- Insurance Claim

Information Sent To:

Name: _____
Address: _____ City: _____ Zip Code: _____
Phone Number: _____ Medical Record Fax Number: _____

By completing this authorization form, I agree that I understand I have the right to revoke this authorization at any time. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization. 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. The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in my providers Notice of Privacy Practices. A fax or photo copy of this authorization shall be considered valid as the original. This authorization is effective for one year from the date on which it was signed.

Signature: _____ Date: _____
Relationship: _____