SALINE MEDICAL SPECIALTIES

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City & State: _____ Zip Code: _____

Phone Number: _____ SMS PCP **(Check)**: ☐ Dr. Gutierrez ☐ Christina Dux, APRN

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
- ☐ Other:_____

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 by 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: _____