MARLBORO INTERNAL MEDICINE
RELATIONSHIP ■ RESPECT ■ RESULTS

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ **SS#:** _____ **DOB:** _____

I, hereby, authorize_____ to ☐ disclose my protected health information to and/or ☐ obtain my protected health information from:

Name: _____ Phone: _____
Address: _____

I understand that my health record may include *general* information related to my mental health, drug/ alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date this authorization was signed. I authorize the release of the following information for dates of service from _____ through _____.

GENERAL RECORDS

__ Cardiac Studies- Heart
__ Consultations
__ Discharge Summaries
__ EEG/EMG/Sleep Studies
__ Emergency Service Records
__ Immunization Records
__ Laboratory Reports
__ Office/Clinic notes for Dr. _____
__ Operative/Procedure Reports
__ Pathology Reports
__ Patient Discharge Care Form
__ Problem List
__ Pulmonary Studies-Lung/Respiratory
__ Radiology Reports
__ Rehabilitation Notes- PT/OT/Speech
__ OTHER(specify)_____

STATUTORILY PROTECTED RECORDS

__ Abortion
__ Alcohol/Drug Abuse
__ Domestic Violence Counseling
__ Genetic Testing
__ HIV/AIDS Results/Treatment
__ Psychiatric Health-including Psychotherapy notes
__ Sexual Assault Counseling
__ Sexually Transmitted Diseases
__ OTHER(specify)_____

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

__ Appointment with Specialist
__ Transferring Care to New Provider
__ Attorney/Legal Case
__ Disability/Insurance Application/Claim
__ Personal Use
__ Pre-employment
__ OTHER(specify)_____

I UNDERSTAND THAT:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information to be disclosed as provided in the Notice of Information Practices.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release Marlboro Internal Medicine from any legal liability that may arise from the disclosure or re-disclosure of this information.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____ _____ _____
Signature of Patient/Parent/Legal Representative* **Date** **Signer's Relationship to Patient**

_____ _____
Witness to Signature **Date**

***If signing as a legal representative, also provide appropriate paperwork to support representative status.**