Authorization for Release of Health Information

Patient Name _____ Date of Birth _____

The person named above (or authorized representative) must indicate when this authorization expires:

- ☐ When the information is received
- ☐ In one year
- ☐ On date: _____

The person named above is or has been a patient of:

Provider/Facility _____

Address: _____

_____

Phone: _____

Fax: _____

The person named above (or authorized representative) herby authorizes Hicksville Direct Primary Care to:

- ☐ Request health information/records from date(s) _____
- ☐ Request records regarding assessment, diagnosis, and treatment of patient's condition(s):

_____

- ☐ Other: _____

I also hereby authorize release of information regarding:

	Initials
☐ Alcohol or Drug abuse/treatment	_____
☐ Mental Health treatment	_____
☐ HIV status/treatment	_____

This information will be used or disclosed for the following purpose:

☐ at the request of the person named above (or authorized representative)

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Patient or Legal Guardian, if applicable

I do not have to sign this authorization in order to receive treatment from **HDPC.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Hicksville Direct Primary Care
100 N Main Street
Hicksville, OH 43526