Ranch View Family Medicine

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Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth:_____

Previous name: _____ Phone #: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s):_____
☐ Other:_____

I want my records released from:
Name (or title) and organization_____ Fax: _____
Address: _____City _____State _____Zip_____

You may disclose this health information to:

Name (or title) and organization_____ Fax: _____
Address: _____City _____State _____Zip_____

Reason(s) for this authorization (check all that apply):

☐ at my request
☐ other (specify)_____
_____
_____
☐ Changing physicians
☐ Referred to Specialist
☐ Insurance/Attorney

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)