BACKUS HEALTH CENTERS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Social Security #_____

Date of Birth _____ Treatment Date(s)_____

AKA (Other names) _____

I hereby authorize CONNCare/Backus Health Centers to disclose my individually identifiable health information to _____

_____

(Name & address of individual, organization or agency and address)

in the manner described below.

I hereby authorize _____

(Name and address of individual, organization or agency and address)

to disclose identifiable information in the manner described below to CONNCare/Backus Health Centers.

1. Information should be delivered via (select one)		Mail (provide address):		
		Fax (provide fax number):		
		Pick-up (provide name of individual picking up information):		
2. Purpose of this disclosure (check all that apply)		Continuation of medical care		Attorney
		Substantiation of payment claims		Personal use
		Other (specify):		
3. Information to be disclosed (include dates where appropriate)		Emergency Records		Consultations
		History & Physical		Physicians' orders
		Progress Notes		EKGs
		Operative Note		Physical Therapy Record
		Laboratory/Pathology Reports		Diagnostic Imaging Exams
		Discharge Summary		Entire Record
		Other (specify):		
4. If you are the legally authorized representative of the patient, describe the scope of your authority to act on the patient's behalf		Parent		
		Durable Power of Attorney for Health Care (attach proof of authority)		
		Legally Authorized Representative (attach proof of authority)		
		Personal Representative of the Estate (attach proof of authority)		
		Other (specify and attach proof of authority)		

5. I understand that the disclosure of information related to Alcohol/Drug testing and treatment, Human Immunodeficiency Virus (HIV) test results, and/or Mental Health Records requires the use of HIPAA Form – Authorization Special and the disclosure of Psychotherapy Notes requires the use of HIPAA Form – Authorization Psychotherapy.

6. **I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.**

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

8. I understand that this authorization will expire in _____ days.

Signature of Patient of Legally Authorized Representative _____ Date _____

Relationship to Patient _____ Witness _____

ID Checked by _____