



## AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

In accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder governing the privacy of health information, this notice informs you of the purpose of the form and how it will be used.

**PRINCIPAL PURPOSE(S):** This form is to provide Sanitas with a means to request the use and/or disclosure of an individual's protected health information.

**ROUTINE USE(S):** To any third party or the individual upon authorization for the disclosure from the individual, **within 3 to 5 BUSINESS days**, for: personal use; insurance; treatment or continued medical care; school; legal; retirement/separation; or other reasons as specified below.

**DISCLOSURE:** Voluntary. Failure to sign the authorization form will result in the non-release of the medical records.

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

- I am the client and hereby authorize the use or disclosure of health information, including protected health information, about me as described below.
- I am the client's representative and understand and agree to the provisions of this authorization on behalf of the patient. My authority to act on behalf of the patient is as follows: \_\_\_\_\_

**By signing this form, I authorize the release of health information, including protected health information. I authorize Sanitas to:**

disclose to \_\_\_\_\_  obtain from \_\_\_\_\_

Please enter provider name & contact information \_\_\_\_\_

Please enter provider name & contact information \_\_\_\_\_

**INFORMATION MAY BE DISCLOSED BY:** Sanitas and any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

### INFORMATION TO BE DISCLOSED: (initial Selection)

- General Medical Record(s), including TB  Progress notes  Consultations  
 History and Physical Results  Immunizations  Family Planning  Prenatal Records  
 Diagnostic Test Reports Specify Type of Test \_\_\_\_\_  
Other: (specify) \_\_\_\_\_ Specify dates of service: \_\_\_\_\_



**By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the disclosure of the type of highly confidential information indicated next to my signature.**

- DNA/Genetic Testing \_\_\_\_\_
- Alcohol/Substance Abuse Service Provider Client Records \_\_\_\_\_
- Mental Health Records \_\_\_\_\_
- Psychologist/Psychotherapeutic Notes and Records \_\_\_\_\_
- Marriage/Family Therapist or Clinical Social Worker Records \_\_\_\_\_
- Child Abuse or Neglect/Early Intervention \_\_\_\_\_
- Sexual Assault \_\_\_\_\_
- Sexually Transmitted Disease \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**

- Treatment
- Personal Use
- Billing/Payment
- Other (specify): \_\_\_\_\_

**EXPIRATION DATE:** This authorization will expire (insert date or event) \_\_\_\_\_ I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

**REDISCLASURE:** I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**CONDITIONING:** I understand that completing this authorization form is voluntary and that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.

**REVOCAION:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. 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, Medicaid and Medicare.

**FEES FOR COPIES:** I understand that federal and state laws permit certain fees to be charged for the copying of patient records and that I may be charged fees in accordance with such laws.

***I request and authorize the disclosure of information described above.***

\_\_\_\_\_  
Patient/Guardian/Caregiver Signature

Date     /     /      
mm / dd / yy

\_\_\_\_\_  
Printed Name Patient/Guardian/Caregiver

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness (optional)

Date     /     /      
mm / dd / yy