

Lincoln Internal Medicine Associates

Authorization to Use or Disclose Health Information

I authorize: _____
(Name/Title/Organization (Recipient))

Address: _____

Phone number: _____ Fax number: _____

to use or disclose the following information on: _____
(Patient Name and Date of Birth)

To: _____
(Name/Title/Organization (Recipient))

Address: _____

Phone number: _____ Fax Number: _____

Please disclose the following information from my records for:

Dates __/__/__ to __/__/__

- History and Physical
- Physician Progress Notes
- Laboratory Reports
- Medication List
- X-Ray Reports
- Entire Record
- Other (Specify) _____

I understand that the information in my health recorded may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse. I am authorizing the release of the following information:

Sexually transmitted disease	yes _____	no _____
Acquired immunodeficiency syndrome (AIDS)	yes _____	no _____
Human immunodeficiency virus (HIV)	yes _____	no _____
Behavioral or Mental Health services	yes _____	no _____
Treatment for Drug or Alcohol abuse	yes _____	no _____

OVER

This information will be used for the purpose of:

- For the purpose of the patient's use
- Treatment and continuation of care
- Insurance
- Legal Proceedings
- Other (Specify Use) _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released or used in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, even, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that a photocopy or a faxed copy of this authorization will be considered as valid as the original.

Signature of Patient or Legal Representative Date

If signed by the Personal Representative, Note relationship to patient

Witnessed by: _____