AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION
Use and/or Disclosure of Medical Records

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

Patient's Name: _____ Patient Account #: _____

Patient's Social Security Number: _____ Date of Birth: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

I give my authorization for my protected health information to be used/or disclosed as described below:

☐ To: ☐ From:

Olde Towne Medical and Dental Center
5249 Olde Towne Road, Suite D
Williamsburg, Virginia 23188
P: (757) 259-3258
F: (757) 220-1953

☐ To: ☐ From:

Name: _____

Location: _____

_____

Phone/Fax #: _____

Purpose for which disclosures are to be made:

☐ Permission to discuss Protected Health Information with individual specified above

☐ Continued Care ☐ Transfer Care ☐ Other: _____

Information to be disclosed:

☐ All Medical Records ☐ History and Physical Exam ☐ Laboratory Reports ☐ _____

☐ Dental Records ☐ Immunization Records ☐ Billing Statements ☐ _____

The following items must be checked to be included in the use and/or disclosure of other health information:

☐ HIV/AIDS related information and/or records ☐ Mental health information and/or records

☐ Genetic Testing information and/or records ☐ Drug/Alcohol diagnosis, treatment or referral information

3. ENDING THIS AUTHORIZATION AND/OR CHANGING YOUR MIND ABOUT THIS INFORMATION

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire 60 days from the date signed below unless revoked earlier. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request. In addition, I understand that if I am giving this authorization as a condition of obtaining coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

4. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. I also understand that if the person(s) or entity(s) that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Olde Towne Medical Center, its employees, and my physicians from all liability arising from this disclosure of my health information.

5. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ **Date:** _____

If this authorization form is signed by a personal representative for the individual patient:

Relationship to Individual Patient: _____

Personal Representative's Name: _____

Print name

_____

Signature

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Place the authorization in the individual patient's medical record.