COMMUNITY CARE PHYSICIANS

GENERAL

PATIENT HIPAA AUTHORIZATION

THIS IS NOT A MEDICAL RECORDS REQUEST FORM. TO REQUEST A COPY OF YOUR RECORDS, PLEASE SEE THE FRONT DESK OR VISIT www.communitycare.com

Patient's Full Name (Last, First) **Patient's Date of Birth**

Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **RELEASED or SHARED BY Community Care Physicians** to the following:

Name(s)/Entities (please include address and phone number):_____

_____

_____

Step 2: What Can We Share?

I authorize the release of the following health information:

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

My Sensitive Information:

Please Initial: _____: I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information below. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

DO NOT INCLUDE MY:

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

Reason for Release:

☐ At request of patient ☐ Transferring Care out of CCP to a New Provider ☐ Legal Request ☐ Other:_____

Step 3: When Does this Authorization Expire?

This authorization will expire on_____

{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. This authorization may include disclosure of information relating to all Community Care Physicians' offices I have visited. I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____ _____

Print Name of Patient or Legal Guardian ***Signature of Patient or Legal Guardian***

Date: _____ ***Relationship to Patient***: _____