Patient Authorization for Disclosure of Protected Health Information

Patient Name (please print)

_____ _____ _____
Name Birthdate SS#

Purpose of request - I authorize:

_____ ____ Mail It
Provider Name / Organization

_____ ____ Fax it to (307) 686-7420
Address

_____
City, State, Zip

to disclose or provide protected health information, about me, to

Gillette Internal Medicine Associates, P.C.
407 S. Medical Arts Court, Suite D
Gillette, WY 82716-3372
(307) 682-0400, Fax (307) 686-7420

Description of information to be disclosed - I authorize the above named provider to disclose the following protected health information about me to **Gillette Internal Medicine Associates, P.C.**:
(<u>what information</u> do you want to be released, AND what <u>dates of service</u>, be specific):

Date(s) of Service: _____

____ Progress Notes ____ Laboratory/Pathology ____ Billing
____ History/Physical ____ EKG/GXT ____ X-ray
____ Medicines ____ Complete Medical Record
____ Other: _____

Purpose of disclosure – (<u>why</u> are you releasing this information about yourself):

____ Continue medical care ____ Transferring care to GIMA
____ Personal use ____ Surgery
____ Other: _____

Expirations or termination of authorization – This authorization <u>will expire at the end of one year from the time you sign it</u>, unless you specify an earlier termination.
Date you want this authorization to end: _____

Right to revoke or terminate –You have specific rights to revoke or terminate this authorization by submitting a written request to the Privacy Manager of the above named provider.

Redisclosure – We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will <u>no longer</u> be the responsibility of the releasing authority**.**

_____

Patient signature Relation/Authority Today's Date

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