Authorization or Disclosure of Health Care Information

I hereby authorize ClearChoiceMD to disclose my protected health information from my health record with no limitations placed on history of illness, or diagnostic and therapeutic information, including any treatment for alcohol or drug abuse*, psychiatric impairments, HIV/AIDs related illnesses or genetic testing. I understand that authorizing the use or disclosure of the information identified below is voluntary. I need not sign this form to ensure healthcare treatment.

*I understand that federal regulations (42CFR part 2) prohibit the re-disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations.

To release your medical information from ClearChoiceMD, you must complete all sections of this form.

Patient Name:____**Date of Birth**:_________________

Address:____

Specific information to be released for dates of service: **Start**:___________**End**:_______________

[ ] Drug and/or Alcohol Screen results

[ ] Results of Physical Examination

[ ] Workers Compensation Medical Form

[ ] Medical Record including Discharge Summary, History and Physical, Lab reports, Procedure Notes, Radiology Reports and images, Problem Lists and medications

<u>Release Information to</u>: ____

Phone:______________Fax:________________________

<u>Purpose of Disclosure</u>: [ ] Own Records [ ] Insurance Claim [ ] Employment Purposes

I understand that this authorization can be revoked in writing at any time. Written revocation must be delivered to ClearChoiceMD. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released. This authorization shall be valid for 1 year unless otherwise specified.

*I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting its confidentiality.

____ __________________

Signature of Patient **Date**

____ __________________

Relationship and/or authorizing if signed by person other than patient **Date**

____ __________________

Signature of Witness **Date**

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