Release of Information

Date of upcoming appointment:
_____/_______/________
STAT Request please

Authorization for Use and Disclosure of Protected Health Information

Transfer of Primary Care

1. I authorize the following disclosure of my protected health information.
2. I may revoke the authorization at any time by providing a written statement to SEL Health Clinic. (The revocation will not impact protected health information already released while my permission was in effect. However, further release of that health information will be prohibited without my specific authorization).
3. My treatment will not be conditioned on whether I sign this.
4. Once my protected health information is disclosed, it may no longer be protected by federal or state law and may be re-disclosed to other parties (however the SEL Health Clinic will not release protected health information without patient authorization).
5. Release of protected health information **from**: (Office name and city/state):
   ____
6. Office name and city/state to **receive** protected health information:
   ____
7. Purpose of disclosure: ______________________________
8. Please release the following protected health information (check those that apply):

______ Last year of records ______ Last 6 months of Lab Results ______ Medication List

______ Last Pap Result ______ Immunization Record ______ Last Mammogram

______ Colonoscopy Report ______ ADHD Testing results ______ Imaging results

______ Sleep Study Results ______ Other Records (Please specify) _________________________

Expiration date of authorization: ____________ (If no date is filled in, this authorization shall expire one year from the Date of Request unless revoked sooner.)

*Specific healthcare records require your **initials** for authorization, otherwise they are excluded from the information released. Please specially authorize the following information to be included in this medical release:

______HIV (AIDs Virus) _____Psychiatric/Mental Health

______Sexually Transmitted Disease _____Drugs and/or Alcohol use

Date of Request: ________________________ Date of Birth: ____________________________

Print Patient Name: ___________________________ Patient Signature: ___________________________________

Parent/Guardian Name: ________________________ Parent/Guardian Signature: ____________________________

OUR CLINIC DOES NOT ACCEPT RECORDS ON CD'S OR FLASHDRIVES. IF OVER 50 PAGES, PLEASE MAIL RECORDS