SEL HEALTH CLINIC

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 all 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