Healthe CLINIC

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL RECORDS

Patient Name: ____ Date of Birth: ___________________________

Address: ____

Phone: ____ E- Mail Address: _________________________________

I hereby authorize Cerner Health Connections, Inc. d/b/a Health*e* Clinic, to release the medical information described below

to: ____ [name of person/entity] at

____ [address] _________________________ [fax number].

This Authorization applies to the following information [mark those that apply]:

☐ Any and all records in the possession of Health*e* Clinic, including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released.]
☐ Records regarding the following condition or injury ______________________which occurred on or about ________.
☐ Records covering the period of time ____________________ to _______________.
☐ Other [please specify – include dates]____.

My protected health information may be used or disclosed under this Authorization by the above listed persons/entities for the following purposes:

☐ Personal
☐ Transfer of care
☐ Continuation of care
☐ Other: _____________________

How information is to be received:

☐ Encrypted Email
☐ US Mail - Paper format
☐ Fax
☐ Pick up Healthe Clinic (WHQ/REA/INN)

This Authorization expires on: ____________.

I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.

- I also understand that certain records/information may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol, drug treatment or communicable diseases, and, unless otherwise specifically indicated, I am requesting that any and all such protected records be released under this Authorization.
- I also understand that I may revoke this Authorization at any time by delivering a written revocation to Health*e* Clinic.
- If I revoke this Authorization, it will have no effect on actions already taken in reliance of this Authorization.
- I know I may refuse to sign this Authorization and that my treatment, payment for my treatment or my enrollment or eligibility for benefits will not be affected unless my treatment includes research or the reason for my treatment is to disclose information to another.
- I have read and understand this Authorization. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records/information upon presentation of a photocopy of this Authorization.

____ ____

Signature of Patient/Personal Representative Date

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Relationship to Patient