Heartland Family Medicine, P.C.

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AUTHORIZATION FOR USE OF OR DISCLOSURE OF HEALTH INFORMATION

This authorization is effective for 180 days from the date on which it is signed. I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Heartland Family Medicine based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatments, payment, enrollment in a health plan, or eligibility for benefits. I understand that if the person or entity receiving authorized information is not a health plan or health care provider, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT IDENTIFICATION:

Name ____________________

Date of Birth ____________ Phone ____________

Parents/Previous Name(s) ____________________

PROVIDER:
(Who is releasing the information)

Name ____________________

Address ____________________

City ____________ State ______ Zip ______

REQUESTER:
(Where you want the information sent)

Name ____________________

Address ____________________

City ____________ State ______ Zip ______

INFORMATION REQUESTED:

- ❑ Complete Records
- ❑ Lab Data, Date ____________
- ❑ X-ray Data, Date ____________
- ❑ EKG, Date ____________
- ❑ Progress Note, From ____________ To ____________
- ❑ History & Physical, Date ____________
- ❑ Discharge Summary, Date ____________
- ❑ Immunization Record ____________
- ❑ Other, specify ____________

A specific authorization is required to release the following information. Initial and check if you want this information released:

Initial ______ ❑ HIV ❑ Drug/Alcohol Information ❑ Mental Health

PURPOSE OF RELEASE:

- ❑ At My Request
- ❑ Insurance Coverage
- ❑ Transferring Medical Care
- ❑ Moving
- ❑ Other, specify ____________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE ____________________ **DATE** ____________

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT ____________________