SUMMIT MEDICAL GROUP

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations:

Patient Name _____ Date of Birth_____
Address_____ Telephone_____
_____ Patient No._____
Covering the period(s) of health care:
From (date)_____ To(date)_____, and

2. Information to be disclosed (check as many as appropriate):
   - ❑ Complete health record(s), OR

   ONLY:
   - ❑ Consultation reports
   - ❑ History & Physical Examinations
   - ❑ X-Ray Reports
   - ❑ Progress (Visit) Notes
   - ❑ Laboratory Tests
   - ❑ Photos, Tapes, X-Rays or Any Images
   - ❑ Billing/Financial
   - ❑ Behavioral Health

3. _____(Initials) I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records. THIS PROVISION MUST BE INITIALED BY PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

4. This information is to be disclosed to (name & address) Information disclosed by (name & address)

_____ _____
_____ _____
_____ _____
for the purpose(s) of: _____, or
   - ❑ At the request of the patient

5. This authorization will expire on _____, not to exceed 1 year. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I fail to specify a date or otherwise revoke this authorization, this authorization will expire 1 year from the date signed below.

6. I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: **1.** Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. **2.** Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Signed: _____ _____
Patient Date

_____ _____
(OR) Legal Representative Date

_____ _____
Witness Date

Copy to be given to patient following signature. **Revised 5/19**