JAVERY
PAIN INSTITUTE

Authorization For Use or Disclosure of Medical Record Information

Med Rec #:_____

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip:_____ Work Phone: _____

Release Information To

I hereby Authorize my Health Care Provider to release my medical record information to / obtain information from:

Name/Facility: _____ Attention:_____

Address: _____ Phone: _____

City: _____ State _____ Zip:_____ Email/Fax: _____

Purpose of Request: ○ Referral or 2nd Opinion ○ Other _____

○ Transfer from Practice/Reason?_____ ○ Personal

Preferred Output (paper is standard)
○ Paper ○ Electronic

Information to be Released

COPY FEE: *Pursuant to State Law establishing reasonable fees for copying medical records, and the Omnibus Provisions of HIPAA, we reserve the right to charge a cost based fee for patient requests. Please see the accompanying letter.*

○ Please provide a five year summary from my records.

○ Please provide my entire medical record.

○ Other - please be specific, include dates and MD's under comments.

Comments

Authorization to Release Protected Information

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one *Initial each line below to confirm your choices*

I ☐ DO ☐ **DO NOT** want **Mental Health or Psychotherapy Notes/Information** released _____

I ☐ DO ☐ **DO NOT** want **HIV Tests & Related Information** released _____

I ☐ DO ☐ **DO NOT** want **Alcohol and/or Substance Abuse Information** released _____

I ☐ DO ☐ **DO NOT** want ***Genetic Testing Information** released _____

I ☐ DO ☐ **DO NOT** want **Social Worker Communication Information** released _____

I ☐ DO ☐ **DO NOT** want **Rape/Sexual Abuse Information** released _____

I ☐ DO ☐ **DO NOT** want **Developmental Disability Information** released _____

I ☐ DO ☐ **DO NOT** want **Sexually Transmitted Disease (STD) Information** released _____

I ☐ DO ☐ **DO NOT** want information about _____ released _____

Other sensitive information?

STOP Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here _____ **Date Here** _____

Patient's Signature **Date**

Sign Here _____ **Date Here** _____

Parent/Legally Recognized Representative Signature** **Date****

Know Your Privacy Rights Refer to the HIPAA "PRIVACY NOTICE"

This Authorization is valid for one year unless you specify otherwise (enter expiration date) _____. You may revoke this Authorization at any time by providing a written statement, except to the extent that the Toledo Clinic has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

** If you are the legally recognized represenatative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. The Health Care Entity will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization.