Healthcare Partners
Family Medicine

1501 N US Hwy 441 Suite 1704, The Villages, FL 32159
Phone: 352-750-4333 | Fax: 352-750-2023

Records Release Authorization

I, _____, (print clearly) specifically authorize **HealthCare Partners Family Medicine** to request my protected health information from the specialist or medical practice named below for the purposes of treatment and health care operations.

Description of the information to be used or disclosed (*check all that apply*):

[ ] Any and all Records* [ ] Diagnostic Reports Only [ ] Lab Results Only [ ] Immunizations
[ ] Chart Notes Only [ ] Consultations Only [ ] Other _____

*May not include mental health treatment records, psychological services and social services information, including communications made by patient to a social worker or psychologist.
*May not include communicable disease and infection information (which include venereal disease "VD", tuberculosis "TB", Hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC").
*May not include alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

Name of the specialist or other medical practice, address, and fax number:

_____
_____
_____

HealthCare Partners Family Medicine shall send information ONLY to the above address and /or fax number. Any disclosure of the patient's protected health information to another address or fax number will require a separate authorization.

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. For the revocation of this authorization to be effective, **HealthCare Partners Family Medicine** must receive the revocation in writing with my signature.

This authorization shall expire on _____. After this date, **HealthCare Partners Family Medicine** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If date left blank, this is a lifetime authorization for release of information.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have read a current copy of HEALTHCARE PARTNERS 's NOTICE OF PRIVACY PRACTICES compliant with HIPAA Omnibus Privacy Rules of March 2013. I have also read a current copy of the facility's:

- FINANCIAL POLICY STATEMENTS
- INFORMED CONSENT FOR INTEGRATED ALLOPATHIC/HOMEOPATHIC/HOLISTIC MEDICAL TREATMENT

As required by the Privacy Regulations, _____ from
Printed Name of Staff Member

HEALTHCARE PARTNERS has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **HEALTHCARE PARTNERS** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

☐ I wish to receive a personal copy of all disclosures I have just read and signed.

☐ I wish to object to the following in the "Notice of Privacy Practices:"

_____

_____

If you wish to file a "Request for Restriction" or "Request for Alternative Communications"" of your Protected Health Information, please contact our Medical Records staff.

By way of my signature:

☐ **I certify that I provide HEALTHCARE PARTNERS with my authorization and consent to use and disclose my PHI for the purposes of treatment, payment, and health care operations as described in the "Notice of Privacy Practices."**

☐ **I certify that I have read and understand the financial policy of HEALTHCARE PARTNERS and I agree to be bound by its terms. I also understand and agree that such terms can be amended from time-to-time by the practice.**

☐ **I certify that I have read and understand the statements in the Informed Consent for Integrated Allopathic/Homeopathic/Holistic Medical Treatment received at HEALTHCARE PARTNERS.**

_____ _____
Signature Date

_____
Print Name

_____

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

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Authorization to Use or Disclose Protected Health Information

Patient Name:_____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *HEALTHCARE PARTNERS* **may not use or disclose your protected health information (PHI) except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my PHI to the following person(s), entity(s), or business associates of this office:

_____

_____

Patient Health Information authorized to be disclosed: **Diagnostic Reports** ☐ **Lab Result only** ☐

Any and all records* ☐

- ☐ **Any and all records including communicable disease and infection information (i.e. VD, TB, Hepatitis B, HIV, AIDS and ART) ONLY.**
- ☐ **Any and all records including mental health treatment records, psychological services and social services information ONLY.**
- ☐ **Any and all records including alcohol and drug abuse treatment information ONLY.**

Other (specify) _____

* May not include mental health treatment records, psychological services and social services information, including communications made by patient to a social worker or psychologist. May not include communicable disease and infection information (which includes venereal disease "VD," tuberculosis "TB," Hepatitis B, Human Immunodeficiency Virus "HIV," Acquired Immunodeficiency Syndrome "AIDS," and AIDS related complex "ART.") May not include alcohol and drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

For the specific purpose of (describe in detail)
Patient or authorized representative's request Other: _____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____ ☐ until I withdraw authorization. This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of PHI being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
   I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected PHI.

_____ _____
Signature or Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of HEALTHCARE PARTNERS *Date*