

AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME: _____

Any Other Previous Names: _____ Date of Birth: _____
Patient Address: _____ Phone Number: _____
City: _____ State: _____ Zip: _____ Email: _____

I hereby Authorize CareMedica to:

Please choose one: Release my Medical Information to Obtain medical information from
Name/Facility: _____ Attention: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip: _____ Fax #: _____
Purpose of Request: Personal Referral or 2nd Opinion Legal Insurance
Other: _____
Workers Comp (only) _____ Date of Injury _____ Body Part Treated _____

Specific Records/Report(s) to be released: (allow 7-10 days for turnaround of request)

Date of Service: _____
 Consultation/Progress Reports Radiology Reports Labs
 Physical Therapy Notes All Immunizations Med List Problem List
 Other Please Specify _____ Bills
 Enter Record (ONLY when subsections of the record will not serve the intended purpose of the disclosure.)

Restricted Authorization to Release Protected Information:

IMPORTANT- It is extremely important that you select either "DO" or "DO NOT" for each item contained in this section Authorization to Release Protected Information. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.
Release Records? Check one

- I DO DO NOT want **Mental/Behavior Health or Disability Services Provider Documentation** * released.
I DO DO NOT want **HIV/AIDS Screening Test Results** released.
I DO DO NOT want information about **Alcohol and/or Substance Abuse Treatment** *** released.
I DO DO NOT want **Genetic Testing/Test Results** ** released.
I DO DO NOT want **Confidential Communications with a Social Worker** released.
I DO DO NOT want information about **Rape/Sexual Assault Victim's Counseling** released.
I DO DO NOT want **Child/Elder Abuse or Neglect & Abuse of an adult with a Disability** released.
I DO DO NOT want information about **Sexually Transmitted Diseases (STD's)** released.
I DO DO NOT want information about **Domestic Violence Victims Counseling** released.

*This Authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general Medical Facility.

Sign Here → _____ Date Here → _____
Signature of Patient's _____ Date

Signature of Personal Representative _____ Date _____ Relationship to Patient or authority to act for patient _____

I understand the following:

- A: I may revoke this authorization at any time by providing written notice to the practice.
B: I may not be able to revoke this information if the practice has already take action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance information.
C: The practice will not condition treatment or payment based on my signing this authorization.
D: I am signing this authorization freely.
E: No one has pressured me to sign this authorization.
F: The information disclosed in this authorization for may be subject to re-disclosure by the practice and no longer protected by federal law.
G: I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
H: I have received a copy of this authorization.