Mitchell Clinic, Ltd.

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AUTHORIZATION

FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Date needed by:_____ ☐ Pick up ☐Mail ☐Fax

Today's Date:_____
(THIS FORM WILL EXPIRE ONE YEAR FROM THE DATE ABOVE)

Name of Patient (please print full name):_____

DOB:_____ Phone:_____

Patient's complete address:_____

Name of person requesting records transfer(if other than patient):_____

Relationship to patient:_____

Phone number where you can be reached for questions:_____

The records will be *SENT FROM:*

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

The records will be *SENT TO:*

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

What information do you want sent? Please check the appropriate boxes.

☐ Dictation/Notes ☐ Operative Reports ☐Radiology/Reports ☐Labs
☐ Medication Lists ☐Complete Record ☐ Consults from Dr_____
☐ Other_____ ☐ Specific Timeframe From:_____To:_____

Purpose of Disclosure (please be specific):

☐ Specialist referral ☐Consult/Second Opinion ☐Transfer of Care ☐Insurance
☐Legal ☐Other (Specify):_____

I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected my federal confidentiality rule.
I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released bas on this authorization.
I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Signature of patient:_____ Date:_____