AUTHORIZATION FOR NONROUTINE DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

I AUTHORIZE MCR HEALTH TO:

SEND MY INFORMATION TO:

Person/Facility_____

Address:_____

Phone:_____ **Fax:**_____

OBTAIN MY INFORMATION FROM:

Person/Facility_____

Address:_____

Phone:_____ **Fax:**_____

INFORMATION TO BE DISCLOSED: (Please initial selection)

_____ General (All) Medical Record(s) _____ Office Notes _____ Labs _____ Diagnostics

_____ Other (Specify): _____

PURPOSE OF DISCLOSURE: (Please initial selection)

_____ Continuity of Care _____ Personal Use _____ Other (Specify) _____

I do not agree to have released the following information: _____

_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire in ninety (90) days from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. **I also understand that the records being released may include information related to STD, HIV/AIDS, TB, Drug/Alcohol, Mental Health, and WIC Eligibility.**

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Patient/Guardian/Representative Signature **Date**

_____ _____

Printed Name **Representative's Relationship to Client**

_____

Witness Signature **Date** *** Notary Seal:**

_____

Witness printed Name

_____

Notary signature and date

*Notary needed if the form is not signed in front of an employee.