



Authorization or Disclosure of Health Care Information

I hereby authorize ClearChoiceMD to disclose my protected health information from my health record with no limitations placed on history of illness, or diagnostic and therapeutic information, including any treatment for alcohol or drug abuse*, psychiatric impairments, HIV/AIDS related illnesses or genetic testing. I understand that authorizing the use or disclosure of the information identified below is voluntary. I need not sign this form to ensure healthcare treatment.

*I understand that federal regulations (42CFR part 2) prohibit the re-disclosure of drug and alcohol treatment information without my written consent or as allowed by the regulations.

To release your medical information from ClearChoiceMD, you must complete all sections of this form.

Patient Name: _____ **Date of Birth:** _____

Address: _____

Specific information to be released for dates of service: **Start:** _____ **End:** _____

Drug and/or Alcohol Screen results

Results of Physical Examination

Medical Record including Discharge Summary, History and Physical, Lab reports, Procedure Notes, Radiology Reports and images, Problem Lists and medications

Release Information to: _____

Phone: _____ Fax: _____

Purpose of Disclosure: Own Records Insurance Claim Employment Purposes

I understand that this authorization can be revoked in writing at any time. Written revocation must be delivered to ClearChoiceMD. Revocation will not be effective for the disclosure of healthcare information previously authorized to be released. This authorization shall be valid for 1 year unless otherwise specified.

*I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting its confidentiality.

Signature of Patient

Date

Relationship and/or authorizing if signed by person other than patient

Date

Signature of witness

Date