# HIGHLAND CLINIC

A Professional Medical Corporation

## Authorization to Disclose Health Information

Revision Date: October 2018

**All information that has been gathered on an individual is personal and private. You are not required to release this information. I understand that Highland Clinic, APMC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. Such information cannot be released without authorized permission, except as required by law.**

**Patient Name:** _____
Last Name First Name Middle Initial

**Patient Address:** _____
Street City State Zip Code

**Home Phone:** (___) _____ **Date of Birth:** _____

**I authorize** _____
Name of the Physician and/or Facility Mailing Address City, State, Zip

**To release to** _____
Name of the Physician, Facility, Other, or Self Mailing Address City, State, Zip

**The following specified information:** (Place a mark in the box and specify any dates in the blank line provided.)

- ☐ Entire Record: _____
- ☐ Lab: _____
- ☐ X-ray: _____
- ☐ Other : _____
- ☐ Progress Notes: _____
- ☐ Correspondence: _____
- ☐ Records from other facilities: _____
- _____

**Purpose for disclosure:** ☐Medical Care ☐Legal ☐Insurance ☐Personal ☐Other_____
**I authorize the disclosure of the information described above via:** ☐ Copy ☐ Fax ☐Verbal ☐ Written

**READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

*By signing this form, I understand that I am authorizing the release or disclosure of the requested health information as marked above in accordance with any specifications I have made. I also understand that the health information to be released may include reference to treatment or history of:* ***1)Mental or behavioral health, 2)Alcohol or drug abuse, 3)HIV and/or AIDS.***

***INITIAL IN THE SPACE PROVIDED IF YOU DO NOT AUTHORIZE THE RELEASE OR DISCLOSURE OF THIS INFORMATION.* ___

- This authorization will expire one (1) year from the date it is signed by the patient or legal representative.
- The patient or legal representative may revoke this consent at any time with written request.
- Any health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highland Clinic, APMC or the federal privacy regulations.

_____ _____
Patient or Legal Representative Signature Date Signed

_____ _____
Witness Signature (Only for a Legal Representative) Date Signed

**Office Use Only**
**Payment received: ☐Yes ☐No Payment made via: ☐Cash ☐Check ☐Charge**
**# of the Receipt given for payment received:** _____
**Date form received:** _____
**Date request completed:** _____