CARIDAD CENTER

HEALTH • EDUCATION • OUTREACH

Authorization for Non-Routine Disclosure of Protected Health Information

Patient Name	Date of Birth	SS#	Telephone Number ( ) -
Address			

INFORMATION MAY BE DISCLOSED BY CARIDAD CENTER TO: _____

Patient or Representative (state relationship to patient)

PLEASE INITIAL SELECTED INFORMATION TO BE DISCLOSED:

_____ General Medical Record(s)

_____ Immunizations

_____History and Physical Results

_____ X-Ray Reports

_____Progress Notes

_____ X-Ray Films

_____Diagnostic Test Reports (Specify Type of Test(s)

_____ Consultations

Other (specify) _____

I specifically consent to release information relating to: (initial selection)

____ STD ____ HIV/AIDS _____ TB ____ Drug/Alcohol ____ Mental Health ____ WIC eligibility ____ Early Intervention

PURPOSE OF DISCLOSURE:

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

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 six (6) months from the date on which it was signed.

RE-DISCLOSURE: I understand that once the above information is disclosed, it may be re-disclosed 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.

REVOCATION: I understand that I have the right to revoke this authorization at 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.

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness Date

Client Name: _____ ID #: _____ D.O.B. _____