IDEAL HEALTHCARE SOLUTIONS
50 Oliver Street, North Easton, MA 02356
Ph: 781-562-0468 • Fax: 781-262-8218

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Patient Address: _____ SS#: _____

_____

Patient Telephone: ( ) _____

I authorize the person(s) or organization(s) listed below, to release health information, including copies of my medical record of care, to Ideal Healthcare Solutions for the purpose(s) described below:

NAME: _____ Purpose (check appropriate box(s)

ADDRESS: _____ □ Medical Care

_____

□ Other (please specify)

PH: ( ) _____ _____

FAX: ( ) _____ _____

DESCRIPTION OF INFORMATION TO BE RELEASED (Please check all that apply):

□ Last Physical Exam □ Immunizations □ Lab Reports x 6 months □ Imaging reports x 6 months

□ Last Discharge Summary □ Consultation Reports x 3months □ Other (please specify)

_____
_____
_____

Release of Specifically Protected Health Information

I request and authorize the release of the specific categories of information that I have INITIALED below:
____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST)
____ HIV/AIDS medical treatment information
____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHUR DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR Part 2.)
____ Other(s): Please list _____

Please Continue Completing Form on Page 2

I understand that:

I may revoke my authorization at any time by submitting a written request to the Operations Manager or the Medical Records Supervisor in my Doctor's Office.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

I understand that this authorization will automatically expire 1 year from the date of signature.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed.

Patient's Signature: _____ Date: _____

When the patient is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____ Relationship of representative to patient: _____