BARNARD MEDICAL CENTER

**Authorization for the use and disclosure of Protected Health Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  |
| Please Print | |  | | |
|  | |  | | |
| Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |  | | |
| Purpose of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  | | | |
| **To Release Information To:** | **To Obtain Information From:** | | | |
|  |  | | | |
| Name of Facility/Individual | Name of Facility/Individual | | | |
| Barnard Medical Center |  | | | |
| Street Address | Street Address | | | |
| 5100 Wisconsin Ave, NW, Ste 401 |  | | | |
| City, State Zip | City, State, Zip | | | |
| Washington, DC 20016 |  | | | |
| Telephone/Fax  202-527-7500 Fax: 202-527-7400 | Telephone/Fax | | | |

I specifically authorize the use and disclosure of the following Protected Health Information under the HIPAA Privacy and Security Rules:

Complete Medical Record **OR**  Visit Notes Progress Notes

History & Physical Laboratory Results

Consultation Reports Radiology Reports

Treatment Orders Discharge Summary

Prescription Information

Photographs, videotapes, digital or other images

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I may revoke the authorization in writing at anytime. I understand that such revocation will not have any effect on the information used or disclosed before receipt of my written notice of revocation. Unless earlier revoked, this authorization will expire one year from the date it was signed. I understand that I may choose to restrict the expiration date.

I may request to inspect or copy the information to be disclosed. I may refuse to sign this authorization. I understand that I am not required to sign the authorization to receive treatment. Once release of this information is made to the above named person/organization, my information may be subject to re-disclosure by the recipient.

I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

The information to be used or disclosed pursuant to this authorization may include information relating to (1) AIDS or HIV infection; (2) treatment of drug or alcohol use; (3) mental or behavior health or psychiatric care; or (4) other conditions. You may request restrictions on disclosures of your information, but please note that we are not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Please **DO NOT RELEASE** any information that has been checked below, if it appears in the record (please check all that apply):

Alcohol Abuse/Drug abuse Employer Name/Address

AIDS/HIV Results Home Phone #/Address Psychological/psychiatric conditions Spouse’s Name/ Office Phone #

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorization Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(At most one year from now.)