Clarkston Community Health Center is becoming... MOSAIC HEALTH CENTER

Fax: 404-795-2057

Authorization for Release of Medical Records & Patient Information

Patient Name: _____ Date of Birth: _____

Section 1: Requesting/Releasing Party Information

I request and authorize Mosaic Health Center to release my protected health information to and/or obtain my protected health information from:

Person/Professional/Facility Name:

_____ Address:

_____ Phone

Number: _____ Fax Number: _____

Section 2: Types of Information to be Released

All Medical Records Imaging Results Laboratory Results Consultations and Progress Notes and/or Consultation Verbal Communication Behavioral Health Evaluations Treatment Plan Pharmacy Records Other: _____ Physician's Orders Diagnostic Records _____

Section 3: Purpose for Release of Information

This protected health information is disclosed for the following purpose(s):

_____

_____

___

Section 4: Authorization & Signature

I understand that I may revoke this authorization in writing submitted at any time to Mosaic Health Center, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

I have read this form and agree to the uses and disclosures of the information as described. I understand records released may contain HIV/AIDS, alcohol/substance use treatment information and/or psychiatric/psychological information. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by law 45 C.F.R. § 164.502 (a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature of Patient or Legal Representative:

_____ Date:

_____

If signed by legal representative, relationship to patient: _____