Authorization to Disclose Protected Health Information

Email to HandsOn@Verisma.com, or fax to (503) 376-5049

Patient Information

Patient Name: _____ Date of Birth: _____

Other Names: _____ SSN (last 4): _____ MRN: _____

I authorize Hands On Medicine to disclose to:

Recipient Information

Name of Person or Organization: _____ Telephone #: _____

Street Address: _____ Fax #: _____

_____ Email: _____

Purpose: ☐ Continuing Care ☐ Legal ☐ Insurance Claim/Application ☐ Forms Completion ☐ Patient Request
☐ Other: _____

Format: ☐ Fax ☐ Paper (mail) ☐ CD/DVD (mail) ☐ Pick up at facility ☐ Push to patient portal (where available)
☐ Secure email: _____

Information to be Disclosed:

Dates of Service: _____ to _____ OR ☐ Last Date of Service only

☐ ER Note ☐ History & Physical ☐ Consult ☐ Operative/Procedure Report ☐ Lab Reports ☐ Office Visit
☐ Radiology Reports ☐ Radiology Images ☐ Cardiac/Pulmonary Testing ☐ Immunizations ☐ Bills

This authorization allows Hands On Medicine to use/disclose PHI as I have directed. I understand that:

- I understand that my medical record may include information relating to sexually transmitted infections (STIs), HIV/AIDS, behavioral health treatment, alcohol/substance abuse treatment, reproductive health care and genetic testing results. By checking one of the following boxes, I do *not* want the following information disclosed:
  ☐ HIV/AIDS ☐ STIs ☐ Behavioral Health ☐ Alcohol/Substance Abuse ☐ Reproductive health care ☐ Genetic testing
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protect- ed by federal confidentiality rules.
- I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (ex: Pre-employment physical)
- I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously. This authorization will expire in 90 days, unless I specify a different date here _____.
- I understand that I am entitled to a copy of this authorization.

Patient/Patient Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____