AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE COMPLETE THE ENTIRE FORM

MILL CREEK FAMILY PRACTICE

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH

PREVIOUS NAME *(if applicable)*

REASON FOR DISCLOSURE

☐ Personal Use	☐ Transfer to another provider	☐ Continuity of Care
☐ Legal Use	☐ Other (please specify):	

INFORMATION TO BE RELEASED **FROM**		INFORMATION TO BE RELEASED **TO**	
☐ Mill Creek Family Practice	☐ Other:	☐ Mill Creek Family Practice	☐ Other:
NAME		NAME	
ADDRESS		ADDRESS	
PHONE	( ) -	PHONE	( ) -
FAX	( ) -	FAX	( ) -

TYPE OF INFORMATION TO BE RELEASED

☐ ALL Medical Records	☐ Medical Records *including the most recent* ***two (2) years*** *of care*
☐ Vaccination / Immunization Records	☐ Other (please specify):

AUTHORIZATION END DATE

☐ 90 days from date signed	☐ On (date):
☐ When the following event occurs:	

→→→ **SENSITIVE INFORMATION** ←←←

I DO NOT AUTHORIZE *disclosure of information related to the following condition(s). Check all that apply.*

☐ HIV/AIDS ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ Drug and/or Alcohol Abuse

MY RIGHTS AS A PATIENT

I understand that I do not have to sign this authorization in order to receive treatment or use my health care benefits. I **do** have to sign an authorization form if:

- If I wish to take part in a research study ***or***
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Mill Creek Family Practice, PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a Revocation Form (available from Mill Creek Family Practice, PLLC)
- Write a letter to Mill Creek Family Practice, PLLC

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

SIGNATURE *(PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE)* Date Time

PRINTED NAME *(IF SIGNED ON BEHALF OF PATIENT)* RELEATIONSHIP TO PATIENT (parent, power of attorney, etc.)

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