Hill HEALTH
A Hill Physicians Practice

authorization for release of medical information

Medical Information Release

I hereby authorize _____ (MD/Facility), or other provider of health care ("Authorized Discloser"), to use and disclose my protected health information ("Health Information") as defined by Federal and state law, in the manner described below.

For: patient last name _____

patient first name _____

patient date of birth _____/_____/_____

To: name _____

mailing address _____

city _____ state _____ zip code _____

phone (_____) _____ fax (_____) _____

Any and all of the following Health Information may be disclosed without exception as permitted by this authorization or by law:

☐ Medical Records ☐ Claims/Billing Information ☐ Mental Health Records ☐ Drug/Alcohol Abuse Record

☐ HIV/AIDS Test Results, Diagnosis, Treatment, or other related Information

Patient's Name _____

The above information may be disclosed for the following dates of service:

☐ Any and All Dates of Service ☐ Dates of Service Including: _____

The information may be used only for the following purposes: _____

_____

_____

_____

I understand that my health care will not be affected if I do not sign this form.

I understand that this authorization will expire on _____ or one year from the date of my signature below, whichever is earlier.

— form continued on back

authorization for release of medical information (cont')

I understand that this authorization is voluntary. I understand that I have the right to receive a copy of this authorization. I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to the Authorized Discloser listed above. I understand that I do not have a right to revoke the authorization if it was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the insurance policy. I understand that the Authorized Discloser may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, unless otherwise permitted by applicable law. I also understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulation.

Signature _____ Date _____/_____/_____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care).

☐ Guardian or conservator of an incompetent patient.

☐ Beneficiary or personal representative of deceased patient.

☐ Other _____