physicians
Immediate Care & Medical Centers

Authorization to Use/Disclose My Healthcare Information

Patient name: _____

Date of birth: _____/_____/_____

Previous name: _____

I. MY AUTHORIZATION

A. **I authorize** ☐ *PICMC* or ☐ *(another provider)* _____ to use or disclose the following health care information *(check all that apply):*

☐ All health care information in my medical record **except for items in B below, unless INITIALED**

☐ Health care information in my medical record relating to the following treatment or condition:

_____

☐ Health care information in my medical record for the date(s): _____

☐ Other (e.g., X rays, bills), specify information and date(s) :_____

_____

B. **I specifically authorize the above named providers** to use or disclose health care information regarding testing, diagnosis, and treatment for ***(INITIAL those that apply):***

_____ HIV (AIDS virus)

_____ Sexually transmitted disease

_____ Mental health/ Psychiatric disorders/Depression

_____ Drug and/or alcohol use

C. This health care information may be disclosed to:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

D. **Reason(s) for this authorization** *(check one)*:

☐ at my request ☐ other *(specify)* _____

*II.*My Request to copy my records: I authorize PICMC to copy and provide me with my health care information for the dates: _____/_____/_____, _____/_____/_____, _____/_____/_____

_____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____

I understand that PICMC will provide me with **up to 10 pages** without charge. Requests for records that exceed 10 pages are filled by Secure Health Information Corp. There is a fee for this service.

This authorization ends: *(This document does not permit disclosure of health information created after the date it is signed unless my initials are here _____)* *(check one below)*

☐ in 90 days from the date signed ☐ on (date): _____/_____/_____

☐ when the following event occurs: _____

(no longer than 90 days from date signed)

III. My Rights

I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). **However, I do have to sign an authorization form:**

- 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 do, it will not affect any actions already taken by PICMC 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. A form is available from the PICMC reception desk. Or
- Write a letter to the PICMC Privacy Officer.

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

_____ _____/_____/_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship

(parent, legal guardian, personal representative)