DELTA MEDIX

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient's Name: _____ Date of Birth: _____

Soc. Sec. No.: _____

Organization Providing the Information): _____

Organization(s) or Person(s) to Receive the Information:_____

_____

Specific Description of Information to be Disclosed:

□ Complete Medical Record □ Progress Notes □ Operative Reports □ Imaging/Clinical Lab Reports

□ Other: _____

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated by initialing before each category.

Initials:

_____ HIV/AIDS testing, test results, treatment and related information including documented high risk behavior.
_____ Drug and/or alcohol diagnosis, treatment, test results and reports and referral information.
_____ Mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information.
_____ Venereal disease information.

Purpose of Disclosure: _____

I understand this Authorization will expire upon termination of the physician-patient relationship with any Delta Medix physician, or seven (7) years from the date of the signature below, whichever occurs first.

I understand that I may revoke this Authorization at any time by notifying Delta Medix, P.C. If I do, it will not have any effect on any actions Delta Medix, P.C., took before they received the revocation.

Delta Medix has my permission to obtain my medication history from my pharmacy.

I acknowledge that I have received the Notice of Privacy Practices of Delta Medix, P.C.

_____ Date: _____

Signature of Patient or Representative

You may refuse to sign this Authorization.
We cannot condition treatment on your signing this Authorization.

FINANCIAL STATEMENT

I agree I am responsible for any patient balances as designated by my insurance.

I have read and understand the financial policy and agree to same.

_____ Date: _____

Signature of Patient or Representative