



AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient name: _____ Date of Birth: _____ Contact Phone: _____

I authorize the release of my medical information To / From _____ (Praxis Clinic)
 To / From (physician, office, or person): _____

Address: _____

Phone: _____ Fax# _____

If recipient is a non-Provider person, include an additional identifier, such as Date of Birth: _____

For the following purpose(s): *[describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual"]* _____.

By **INITIALING** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist (must have initials in order for records to be released)

___ **Send entire medical record** (*all information) to the above named recipient

OR *For requests beyond most recent history, patient will be charged a reasonable copy/postage fee up to a maximum of \$50.00).

___ **Send most recent history at no charge to the above named recipient**

**Includes up to 2 years chart notes, 2 years progress notes and last 3 labs or 50 pages, whichever is greater as well as current medications list, allergy list, active problem list and immunization history.*

- | | |
|---|---------------------------------------|
| ___ Clinician office chart notes | ___ Billing statements |
| ___ Laboratory reports | ___ Pathology reports |
| ___ Diagnostic imaging reports | ___ Emergency and urgent care records |
| ___ Medical records needed for continuity of care | ___ Other: _____ |

(FOR DESERT ORTHOPEDICS ONLY) \$10 X-Ray \$15 MRI \$15 Both MRI/ X-Ray

___ Diagnostic Images on Disk (See Front Desk, charges may apply)

The following items must be **INITIALED** to be included in the use or disclosure of other health information

- ___ HIV / AIDS related health information and/or records
- ___ *Mental health/psychotherapy information and/or records *must have documented provider approval in chart before release
- ___ Genetic testing information and/or records
- ___ Drug/alcohol/substance abuse information and/or records

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or have copies of any information to be used or disclosed under this authorization.
- I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.
- I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.
- This authorization will remain in effect for one year from the date of signature unless a stop date is identified.
- I may revoke authorization in writing at any time; this revocation will not apply to information that has already been released in response to this authorization. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640. [insert applicable date or event of expiration]_____.

Signature of Individual or Individual's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Individual