CATONSVILLE PRIMARY CARE CENTER, PA

Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____

Date of Birth _____ **SS #** _____ **Medical Record #** _____

Daytime Phone # _____ **Evening Phone #** _____

Address _____

City _____ **State** _____ **Zip Code** _____

I hereby authorize _____ to use or disclose my protected health information as indicated below to:

Name _____

Daytime Phone # _____ **Fax #** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Information to be released:

From & To Dates _____

- ❑ History and physical exam _____
- ❑ Lab report _____
- ❑ X-ray report _____
- ❑ Consultation report _____
- ❑ Other _____

Purpose of Disclosure:

- ❑ Changing physicians
- ❑ Continuing Care
- ❑ At my (patient) request
- ❑ Workers' Compensation
- ❑ Other _____
- ❑ Second Opinion
- ❑ Legal
- ❑ Insurance
- ❑ School

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ❑ Substance Abuse (including alcohol/drug abuse)
- ❑ Mental Health
- ❑ Psychotherapy Notes
- ❑ HIV related information (including AIDS related testing)

This material shall not be transmitted to anyone without written consent or authorization.

X_____ _____

Signature of Patient or Legal Guardian — Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying **CPCC, PA** , Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

405 FREDERICK ROAD, SUITE 210
CATONSVILLE, MD 21228

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosures of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____

Signature of Patient — Date — Parent/Legal Guardian/Authorized Person — Date

_____

Relationship to Patient

_____ _____

Records Received By — Date

For Office Use Only

Date Requested Filled _____ By _____

_____ Account # _____

Identification Presented — Fee Collected