Cedar Valley Medical SPECIALISTS P.C.
We specialize in you.℠

Mail to: Cedar Valley Medical Specialists, P.C.

Attn: _____

_____

Standard Authorization to Use or Disclose Protected Health Information (PHI)

Section A: I give my permission to release health information for the individual listed below. Read the following information to make sure that it is correct:

Name: _____

Social Security Number:_____ Date of Birth_____ Telephone Number_____

Address:_____ City:_____ State:_____ Zip:_____

Section B: Office/Physician that will provide this health information:

Name:_____

Address:_____

_____

Section C: This information is to be sent to:

Name:_____

Address:_____

_____

Section D: Describe the specific Protected Health Information to use or disclose, including date(s):

MUST BE COMPLETED BEFORE RECORDS RELEASED

☐ **Complete Medical Record**[This would include Psychiatric (mental health) information, HIV and/or Aids related diagnosis, evaluation information, and Substance Abuse(Drug or Alcohol) information] Patient has the right to review information disclosed.

☐ **Partial Medical Record – Do not include the following areas of my records in this release:**

- ☐ Psychiatric (mental health) information
- ☐ HIV and/or Aids related diagnosis, evaluation information
- ☐ Substance Abuse (Drug or Alcohol) information

For the following dates of service:_____

Describe the reason for the release or request of information:_____

☐ At the request of the individual or ☐ Other_____

Section E: I understand that:

- This authorization is voluntary. I am not required to sign this form. CVMS does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. If I do not sign this form, CVMS will not disclose my health information as requested.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any effect on any CVMS actions before they received the revocation.
- Once my health information is disclosed as requested in this authorization my health information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed.
- Information used as a result of this authorization may not be further disclosed by CVMS without the written authorization of the person to whom it pertains.
- I may receive a copy.

Section F: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the individual listed in Section A. This authorization will expire in one year.

Signature of Individual/Individual's Personal Representative:_____Date:_____

Section G: If Section F is signed by a Personal Representative, please complete the information below:

Personal Representative's Name:_____

Relationship to Individual:_____

Personal Representative's Address_____

City:_____ State:_____ Zip:_____ Country:_____

Personal Representative's Area Code & Telephone Number:_____

Date Sent:_____ Initials:_____

Faxed to::_____ Picked up by pt:_____ Mailed to:_____