Medical Release Form

HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Date: April 4 , 20 23

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: Beatrix Buckley
Date of Birth: February 27 , 20 00
Social Security Number: 012 - 34 - 5678

II. AUTHORIZATION. I authorize Charles Blevins ("Authorized Party") to use or disclose the following: (check one)

☑ - All of my medical-related information.
☐ - My medical information ONLY related to: _____
☐ - My medical-related information from _____ , 20 ___ to _____ , 20 ___ .
☐ - Other: _____

Hereinafter known as the "Medical Records."

III. DISCLOSURE. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☑ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _____
Address: _____
Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
Email: _____

IV. PURPOSE. The reason for this authorization is: (check one)

☑ - General Purpose. At my request (general).
☐ - To Receive Payment. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.
☐ - To Sell Medical Records. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for disclosing my Medical Records and will stop any future sales if I revoke this authorization.
☐ - Other: _____

V. TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☑ - On the following date: May 4 , 20 23 .
☐ - Other: _____

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures made based on my original permission cannot be returned.

I understand that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to participate in a research study), and I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: Beatrix Buckley Date: April 4, 2023

Print Name: Beatrix Buckley

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

☐ - Being a Minor. Patient is _____ years old and considered a minor under state law.
☐ - Being Incapacitated. Patient is incapacitated due to: _____
☐ - Other: _____

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☑ - I consent to have the above information released.
☐ - I do not consent to have the above information released.

Signature of Patient: Beatrix Buckley Date: April 4, 2023

Print Name: Beatrix Buckley

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - I consent to have the above information released.
☑ - I do not consent to have the above information released.

Signature of Patient: Beatrix Buckley Date: April 4, 2023

Print Name: Beatrix Buckley