Huguley Medical Associates

A Member of Adventist Health System

CWCC 604
Exhibit A

Authorization for Access, Use and/or Disclosure of Protected Health Information

Patient Name:			**Medical Record#:**
Telephone:			
Address:			**Date of Birth** **/ /**
Street		Apt#	**Today's Date** **/ /**
City	State	Zip	

1. **I hereby request that _____ (enter name of AHS Entity providing access or disclosure).**

   Allow me access to the information requested below

   Provide me with my own copy of the information requested below (circle format you would like: photocopy, electronic, other:_____)

   Disclose the information requested below to the individual or entity listed in item #3

2. **Reason for request:**_____

3. **Disclose the information to the following individual or organization:**

   Name:_____

   Address:_____

   City:_____**State:**_____

   Zip Code:_____**Phone #:**_____

   Fax #:_____

4. **Specific description of information to be accessed and/or disclosed:**

   - □ My medical records
   - □ Complete medical record (except for mental health and/or developmental disability, substance abuse, and/or HIV/AIDS-related information; must be checked separately)

- □ Abstract (face sheet, history and physical, operative report, discharge summary, consults)
- □ Surgical (operative report, pathology report)
- □ Tests results (lab, radiology, cardiology, neurophysiology, respiratory)
- □ Mental health and developmental disability records
- □ Substance abuse records
- □ HIV/AIDS-related information records
- □ Therapy note: Physical, Occupational, Speech, and/or Respiratory Therapy
- □ Other _____
- □ My billing records
- □ Any other personally identifiable information used by AHS Entity to make medical decisions about me.

  Please describe:_____

5. Request access and/or disclosure of records for the following dates of service:

_____

I have read and understand the following statements:

I understand this Authorization will expire on (/ /) or when the following event occurs:

_____

Note: If authorization is for disclosure of mental health records, it must have a calendar date expiration or the information may only be disclosed on the current day.

Note: If this authorization is for research, an expiration date is not required.

I understand that Huguley Medical Associates may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, Huguely Medical Associates will not release the information as requested in this Authorization, and I will be notified of the denial/refusal in writing.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that Huguley Medical Associates will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

I understand that I may revoke this Authorization at any time by notifying Huguley Medical Associates in writing, but if I do, it will not have any affect on any actions Huguley Medical Associates took before it received the revocation.

I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.

I understand requests may be subject to a copying fee.

I understand that I may see and copy the information described on this form if I ask for it, and that I shall receive a copy of this form after I sign it if the request for disclosure was initiated by [AHS Entity].

If this Authorization Form authorizes use and/or disclosure of psychotherapy notes it may not be used to authorize the use and/or disclosure of any other protected health information.

_____	_____/_____/_____
Printed Name of Patient	**Date**
_____	_____/_____/_____
Patient (or *Legal Representative) Signature	**Date**
_____	_____/_____/_____
Witness	**Date**

Please attach court order or other documentation designating the legal representative, as applicable.

Note to the recipient of alcohol or drug abuse records: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.