ISLAND
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Patient Name:	DOB:

1. I hereby authorize the above named medical practice to use, disclose or obtain the following protected health information.

☐ All medical records ☐ Specific medical records only: _____

2. ☐ These records may be obtained from: _____

_____

OR _____

PH: FX:

☐ These records may be released to: _____

_____

_____

PH: FX:

3. This information is being used or disclosed for the following purpose: _____

_____

_____

_____

4. This authorization will expire on: _____

5. I understand that:

a) I do have to sign this authorization in order to receive treatment and that I have the right to refuse to sign this authorization.

b) I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the practice.

c) The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.

d) I have the right to inspect or copy the information to be disclosed as permitted under federal law.

e) I will receive a signed copy of this authorization.

Patient Signature: Date:

Print Name: