zoomcare®

Authorization to Use or Disclose Protected Health Information

Patient Name (Legal): _____
(Legal First Name, Middle Name, Last Name)

Patient Preferred name:_____ Date of Birth: _____ /_____ /_____
(mm) (dd) (yyyy)

Email: _____ Phone Number: (_____) _____ - _____

Street Address: _____

Apt/Unit #: _____ City: _____ State: _____ Zipcode_____

I authorize the use and/or disclosure of the protected health information as specified below:

Release records from:_____
(name of disclosing facility)

Release records to: _____
(name of recipient)

Send Records by (choose one):

❑ Secure Email: _____ ❑ Fax:(_____) _____ - _____
(email address of recipient) *(fax number of recipient)*

❑ US Mail: _____
(complete mailing address of recipient)

Purpose of Release: ❑ Continuing Medical Care ❑ Personal Use ❑ Legal Use ❑ Other _____

Dates and Information to be released:

Dates: ❑ All Dates of Care ❑ Specific Date(s) _____

Information: ❑ All Medical Records ❑ Specific Medical Records: _____

Sensitive Information: I understand that my express consent is required to release any health care information relating to testing, diagnosing and/or treatment for HIV (AIDS virus), sexually transmitted diseases, mental health treatment, drug and/or alcohol use, and genetic testing.

By **initialing below,** I specifically authorize the disclosure of the following information and/or records:

_____ Drug/Alcohol Testing or Treatment _____ Genetic Testing

_____ HIV/AIDS Testing or Treatment _____ Mental Health Testing or Treatment

_____ Sexually Transmitted Disease Testing or Treatment

I understand that I may revoke this authorization in writing at any time by contacting the Health Information Management Department of the above-named entity, except where any action already taken in reliance on this authorization has taken place.

I understand that once my protected health information has been disclosed to the recipient noted above, it may be re-disclosed and no longer protected by federal or state privacy laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal or state law may prevent the recipient from re-disclosing this information.

I may refuse to sign this authorization. My refusal to sign this authorization form will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services. However, you must sign this authorization form when the purpose of healthcare services or research participation is to create or receive healthcare information.

I understand that unless revoked earlier, this authorization will expire **1 year** from the date of signing, or on the following date :___ ___ / ___ ___ /___ ___ ___ ___ or event _____ whichever occurs first.

Relationship to Patient: ❑ Self ❑ Parent of Minor ❑ Legal Guardian ❑ Legal Representative ❑ Other: _____

Signature: _____ Date Signed: _____ /_____/ _____
(Signature of patient or legal guardian)

Print Name: _____

Minor Consent: _____ Date Signed _____ /_____/ _____
(Signature of minor if aged 13-17, if required)

Print Name: _____