AUTHORIZATION TO RELEASE /REQUEST PATIENT HEALTH INFORMATION

Patient Name ____ Date of Birth _____ /_____ / __________

Name ____ Date of Birth _____ /_____ / __________

Name ____ Date of Birth _____ /_____ / __________

Name ____ Date of Birth _____ /_____ / __________

Contact phone #'s ________________________ _________________________________ email _______________________________

❑ I hereby authorize **Albert S. Callie, MD, PC** to send the record of my care to:

❑ I hereby authorize **Albert S. Callie, MD, PC** to request the record of my care from:

____
Organization / Person

____
Street Address City, State, Zip

_____________________ _____________________ _____________________________
Phone Fax# email (if HIPAA compliant)

PURPOSE OF RELEASE:
❑ Moving ❑ Personal use ❑ Specialist Appointment ❑ Transfer to another provider ❑ Daycare / School / Camp ❑ Dissatisfaction

❑ Other ____

TYPE OF INFORMATION TO BE RELEASED (no information will be released unless box is checked)

❑ General records (excluding protected records)
(limited to 3 yrs, including lab/xray reported unless otherwise stated) From ____________ To ____________
❑ Immunization Records only ALL ON FILE
❑ Physical Exam for School / Sports From ____________ To ____________
❑ Other (please specify) ____ From ____________ To ____________

INFORMATION PROTECTED BY STATE / FEDERAL LAW
❑ Drug/Alcohol abuse/treatment & diagnosis From ____________ To ____________
❑ Sexually transmitted diseases From ____________ To ____________
❑ Mental Health Treatment From ____________ To ____________
❑ HIV/AIDS diagnosis/treatment/testing From ____________ To ____________
❑ Genetic Testing Information From ____________ To ____________

THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR, OR 90 DAYS AFTER IT IS SIGNED, UNLESS ANOTHER DATE OR EVENT IS ENTERED HERE: ________________________

This authorization provides that:

- I can cancel this authorization at any time by written notification to Albert S. Callie, MD, PC. , except if this practice has taken action relying on this consent. Information released according to the terms of this authorization cannot be recalled.
- Information used or disclosed pursuant of this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed
- I will receive a copy of this completed and signed authorization form

SIGNATURE ____ DATE: _________________________

RELATIONSHIP TO PATIENT: _____________________________

AUTHORIZATION TO RELEASE /REQUEST PATIENT HEALTH INFORMATION

The fee for providing a copy of your medical record release is $25 for the 1st 20 pages and .50¢ each page thereafter. (Revised 7/16/2013)

Patient Name ____ Date of Birth _____ /_____ / _________

Contact Numbers ( ) ________________________ ( ) _________________________________

- ❑ I hereby authorize **Albert S. Callie, MD, PC** to send the record of my care to:
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____
Organization / Person

____
Street Address City, State, Zip

____
Phone Fax#

INFORMATION TO BE RELEASED:
❑ ASC Medical Records ❑ Entire Record ❑ ASC Billing Record
❑ Other (please specify) ____
Format for records (please check ONLY one box): ❑ MAIL ❑ FAX ❑ PICK UP

PURPOSE OF RELEASE:
❑ Legal ❑ Personal use ❑ Continuing Care ❑ Transfer to another provider ❑ School
❑ Other ____

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION
I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by written notification to Albert S. Callie, MD, PC. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here _______________________________________.
  (Note: If the disclosure is to another employer or financial institution, this authorization will expire 90 days from the date signed by you.)
  Sensitive Records may require specific patient authorization, please check the applicable box below to request the following records.
  ❑ Drug/Alcohol abuse/treatment & diagnosis ❑ Sexually transmitted diseases ❑ Mental Health Treatment
  ❑ HIV/AIDS diagnosis/treatment/testing

SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

____
Signature of Minor Patient Date

____
Signature of Patient or Legally Responsible Party Date

____
Relationship to patient, if not signed by patient

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