The Clinic at Elm Lake

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Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Sex: □ Male □ Female

Address: _____ City: _____ State: _____Zip: _____

Home Ph: _____Cell: _____ SSN: _____ Date of Birth: _____

Marital Status: _____ Emergency Contact: _____ Ph: _____ Relationship: _____

Company: _____ □ Pre-Employ □ Random □ Post Accident □ Reasonable Cause □ Other

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I hereby authorize The Clinic at Elm Lake to use or disclose my protected health information as indicated below to:

□ None
□ Employer
□ Work Comp (including third parties)
□ Other Health Care Providers
Physician or Clinic Name _____
Address: _____
Phone: _____Fax:_____

□ Other Ancillary Providers
Name: _____
Address: _____
Phone: _____Fax:_____

Information to be released:

□ History and Physical Exam
□ Lab Report
□ X-ray Report
□ Consultation Report
□ Medical Records
□ Other _____

Purpose of Disclosure:

□ Legal
□ Insurance
□ School
□ Second Opinion
□ Employer Request
□ Other _____

1. I understand that this authorization will not expire unless requested. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying The Clinic at Elm Lake, PA in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I can have a copy of this form if I request one, after I have signed it.
7. I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ or _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date