AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Today's Date: _____

Patient Name: _____ **Patient No.:** _____

Patient's Date of Birth: _____ **Phone:** _____

Address: _____

I authorize the use and disclosure (release) of my Medical Record information:

From: MD2U – The Leader in Home-Based Primary Care
9200 Shelbyville Road, Suite 530
Louisville, KY 40222
502-327-9100 (Fax) 855-632-8329

To: _____
_____
_____

The purpose of this disclosure:

☐ At the request of the individual ☐ Changing Primary Care Physician ☐ Changing/Seeing Specialist

☐ Other: _____

The information to be released includes:

☐ Last 3 office/progress notes ☐ Labs Reports ☐ Imaging (x-rays/scans)

☐ Treatment Plan or Summary ☐ Continuing Care Plan ☐ Other: _____

_____

I want to exclude the following information from being released:

☐ Chemical Dependency/Substance Abuse ☐ Psychiatric/psychological conditions

☐ Sexually Transmitted Diseases ☐ Alcohol ☐ Drugs

☐ I **do not** want to exclude any information from being released and understand information pertaining to HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions may be included in the information released.

Expiration/Revocation: Unless otherwise noted, this Authorization shall remain in effect for **two years** from the date it is signed. I understand that I may revoke this Authorization at any time by notifying MD2U in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by MD2U before receiving my revocation.

Refusal to sign this authorization in no way affects my treatment, payment, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized re-disclosure whereby the information may not be protected by federal privacy laws.

Signature of Patient/Patient Representative: _____

Representative's Relationship to Patient: _____

Expires: (2 years from date it was signed) or _____.