Your Health PRIMARY CARE

Authorization for Use and Disclosure of Protected Health Information

To be completed if requesting or releasing protected patient information.

I hereby authorize Your Health to use or disclose my protected health information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name _____
First Middle Last

Address _____

Date of Birth _____ Email _____

Phone _____ Social Security Number _____

Information of the practice or provider authorized to **release** the information	
Practice/Provider	
Address	
Phone Number	Fax Number
Information of the practice or provider authorized to receive the information	
Practice/Provider	
Address	
Phone Number	Fax Number
Purpose of Disclosure	Dates of Treatment

INFORMATION TO BE USED/DISCLOSED (please check all that apply)

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Immunization Report
- ☐ Progress Notes
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Entire Medical Record
- ☐ Billing Summary
- ☐ Consultation Report
- ☐ Pathology Report
- ☐ Other _____

I acknowledge that if I undergo treatment for drug or alcohol abuse, psychiatric conditions, or communicable diseases, including HIV/AIDS, this information will be documented in my medical records for the specified individual or facility mentioned above. Your Health shall not make treatment, payment, enrollment, or eligibility for benefits contingent upon the signing of this authorization. This authorization can be revoked or canceled at any time by the patient or their legally qualified representative, provided that the cancellation is submitted in writing. However, this revocation does not apply if:

1. The facility has already taken action based on your request before receiving the cancellation notice; **or**
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

This authorization will automatically expire in 90 days, unless otherwise stated. **Expiration Date:** _____

_____ _____
Signature of Patient or Legally Qualified Representative Date

_____
Relationship of Legally Qualified Representative