South Valley Internal Medicine
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Authorization to Use or Disclose Protected Health Information

(Patient Name) (D.O.B.) (SS#) (Date of Treatment)

I hereby freely and voluntarily authorize (name of facility) to...

_____ Release/Disclose my protected health information to:

_____ Obtain my protected health information from:

(Individual, Facility, or Organization) (Phone number)

(Address) (Fax number)

(City, State, Zip)

The type and amount of information to be used or disclosed is as follows:

- ☐ Entire medical record
- ☐ Most recent History & Physical (Date:_____)
- ☐ Most recent Discharge Summary (Date: _____)
- ☐ Emergency Room report (Date: _____)
- ☐ Lab results (Date: _____ to _____)
- ☐ Current Medication List (Date:_____)
- ☐ Immunization Record (Date: _____)
- ☐ EKG/PFT report (Date: _____)
- ☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written Revocation to the origination facility. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one (1) year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my Health Information Management Information, I can contact the originating facility.

Signature of Patient or Legal Representative Date

Signature of Witness Date

*Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.