



HEALTH FIRST PHYSICIANS AUTHORIZATION FORM

I authorize the specified person(s) to disclose protected health information as follows:

1. Person authorized to make disclosure: _____
[Name of health care provider, insurer, etc.]
2. Person authorized to receive the disclosed information: _____
[Name of party]
3. Recipient's mailing address _____
Number & Street Name City State Zip Code
4. Specific description of the protected health information that may be used or disclosed:

<input type="checkbox"/> Please send the entire medical records (all information) to the above named recipient. The recipient understands these records to be voluminous and agrees to pay all reasonable charges associated with providing this record.	<input type="checkbox"/> Billing statements <input type="checkbox"/> Others
<input type="checkbox"/> Transcribed hospital reports. <input type="checkbox"/> Medical records needed for continuity of care <input type="checkbox"/> Laboratory reports <input type="checkbox"/> Pathology reports <input type="checkbox"/> *HIV/AIDS-related records <input type="checkbox"/> Diagnostic imaging reports <input type="checkbox"/> Clinician office chart notes <input type="checkbox"/> Physical therapy records	<p>The below information must be <u>initialed</u> to be included in other documents.</p> <input type="checkbox"/> **Mental health information: _____. <input type="checkbox"/> **Genetic testing information: _____. <input type="checkbox"/> **Drug/alcohol diagnosis, treatment or referral information: _____. <p>**Federal Regulation, 42 CFR Part 2 requires a description of how much and what information is to be disclosed.</p>

5. The information will be used on my behalf for the following purpose(s):

6. This authorization is limited to the following treatment:

7. This authorization is limited to the following time period:

8. This authorization is limited to a worker's compensation claim for injury:
 (Date) _____
9. This authorization shall expire on the following date or event:
 (Specify date or event) _____
10. I understand that the information received pursuant to this authorization may be disclosed by the recipient and might lose its protected status.
11. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician's clinic where my information is maintained. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature

Date

Print Name

____/____/____
Date of Birth

____-____-____
Social Security Number

Name of personal representative

Description of personal representative's authority