PrimeMed
A Professional Corporation

Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ DOB: _____

Organization Providing the Information: _____

Organization(s) or Person(s) Receiving the Information: _____

Specific Description of Information Disclosed: _____

_____

_____

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

1. **Initials:** ____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented;
2. **Initials:** ____ Drug and/or alcohol diagnosis, treatment, test results and reports and referral information;
3. **Initials:** ____ Mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or
4. **Initials:** ____ Venereal disease information.

Purpose of Disclosure: _____

_____

_____

If this Authorization is for marketing purposes, remuneration (is) (is not) involved. N/A (Circle one)

You must read and initial the following statements:

1. **Initials:** ____ I understand this Authorization will expire on _____ (DD/MM/YR) or on the following event _____

2. **Initials:** ____ I understand that I may revoke this Authorization at any time by notifying PrimeMed, P.C. in writing, but if I do, it will not have any effect on any actions PrimeMed, P.C. took before they received the revocation.

_____

Signature of Patient or Representative Date

_____

Representative's Relationship to Patient

You may refuse to sign this Authorization.
We cannot condition treatment on your signing this Authorization.