NOMS HEALTHCARE

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, (Patient Name) _____ DOB: _____ authorize,

Provider Name _____Phone: _____

Fax: _____

Address: _____

To use and/or disclose my health information as identified below to:

Recipient _____ Phone: _____

Fax: _____

Address: _____

The purpose of this disclosure is:
☐ At the request of the individual, or
☐ Other (please list reason) _____

The dates of patient care covered by this Authorization are:
_____

<u>The following information may be released:</u>

☐ Entire Medical Record
☐ Urgent Care Records
☐ Lab Reports
☐ Pathology Reports
☐ Itemized Billing Statements
☐ Cardiology Report
☐ Other Records as Specified:
☐ Operative Report
☐ All Hospital Records
☐ Radiology/Imaging Records
☐ Emergency Records
☐ Cardiology Report

<u>The following highly confidential information may be released:</u>

☐ *HIV/AIDS health information and/or records
☐ Generic testing information and/or records
☐ *Mental health information and/or records
☐ *Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of How much and what kind of information is to be disclosed.

☐ ***Psychotherapy notes**: (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

I understand that:

- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

- If the person or entity receiving this information is not a health care provider or health care plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected under other applicable state or federal laws and regulations.
- The person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly for doing so.
- I may revoke this authorization at any time by giving written notice to: Privacy Officer, Northern Ohio Medical Specialist, 2500 W Strub Rd, Suite 360 Sandusky OH 44870. I understand that a revocation of this authorization is not effective with respect to actions NOMS Healthcare has taken in reliance on this authorization.
- Unless revoked earlier, this authorization will expire 180 days from the date of signing.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print name of Patient or Legal Representative Date

If signed by a legal representative, please describe relationship to, and legal authority to act on behalf of, the patient:

_____