**COMPLETE THIS FORM ONLY IF YOU ARE ASKING US TO GET YOUR PAST MEDICAL RECORDS FROM ANOTHER DOCTOR.**

Authorization for Disclosure of Health Information

Patient’s Name

DOB

SSN

Phone Number

Street Address

**Authorizes (Doctor from Whom You Wish Us to Get Your Records):**

|  |  |
| --- | --- |
| Name Street Address  |  City State Zip Phone/Fax  |
| **To Release Protected Health Information To:**  | **Mauck Medical Clinic, LLC****917 Pine Ave Ste D, Box 703, Hoxie, Ks 67740****hmauck@mauckmedicalclinic.com**  |

**Information to be Released:**

[ ] Entire Medical Record [ ] Medical History, Examination, Report [ ] Surgical Reports [ ] Treatment or Tests [ ] Hospital Records, Including Reports [ ] Allergy Records

 [ ] Immunizations [ ] Prescriptions [ ] X-ray Reports

 [ ] Billing & Payment Information [ ] Consultations [ ] Laboratory Reports

[ ] Other (Specify) [ ] Only for the Following Dates

I understand that the information in my health record may include information relating to sexually transmitted disease, 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.

 [ ] Yes, I consent to the release of this information. [ ] No, I do not consent to the release of this information.

**Purpose for Need of Disclosure (Check Applicable Categories):**

[ ] Further Medical Care [ ] Personal = At the Request of the Individual [ ] Insurance Eligibility/Benefits [ ] Changing Physicians [ ] Legal Investigation or Action [ ] Other

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a 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 individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that 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 on the following date, event

 or condition: . If I fail to specify an expiration date, event or condition,

this authorization will expire in six months. 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 ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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 questions about disclosure of my health information, I can contact the Office Manager of Mauck Medical Clinic, LLC

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| --- | --- |
| Signature of Patient or Legal Representative   Relationship to Patient (If Legal Representative)  | Date Witness  |