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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *information regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse has special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

TO: _____
Name

_____
Address

_____
City State Zip Code

The medical information will be used for the following purpose:

[ ] Dr. Review [ ] Insurance Review [ ] Other: _____

This authorization is:
[ ] Unlimited (all records, excluding substance abuse, mental health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION This authorization is effective immediately and remains in effect until _____
RESTRICTIONS
Permissions of further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.
Update: As we are now using an outside service there is a charge for obtaining records. You will be billed directly from Clox Health. For any questions call **800-367-1500.**
I have been advised of my right to receive a copy of this authorization and seen our updated charge_____Initial/Date

_____ Signature of Patient/Legal Representative _____ Relationship

_____ Patient's Name (PRINT) _____ Patient's DOB

_____ Patient's Address

_____ City, State, Zip