

Patient HIPAA Authorization to Disclose PHI and Part 2-Protected Records

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

AUTHORIZATION: I hereby authorize Panagia Medical Recovery Clinic, PLLC (“Provider”) to disclose the following documents from my medical record and patient file, in any and all formats or portions now existing or hereafter created (examples of formats are paper, digital, internet) to the recipients (“Recipients”) identified below:

Description of information/documentation to be disclosed: My 42 C.F.R. Part 2-protected records

Recipients: My treating providers, health plans, third-party payers, credit card companies (that I have used to pay Provider(if applicable)), and people helping to operate Provider’s Part 2 program

This protected health information is being used or disclosed at my request for treatment, payment, and healthcare operations. I understand that, except as noted above, my health information may contain information concerning my psychiatric, psychological, mental health, HIV/AIDS, sexually transmitted diseases, and/or related conditions, and I authorize disclosure of same. However, I do not authorize disclosure of any psychotherapy or substance use disorder counseling notes. If Practice intends to use or disclose records to fundraise on its own behalf, I understand that I have the right to elect not to receive any fundraising communications.

This authorization will remain in effect until I revoke it. I understand that I have the right to revoke this authorization, in writing, at any time, except where uses and disclosures have already been made based upon my original consent. I agree that revocation must be communicated in writing to Provider.

I understand that authorizing the disclosure of this information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. I understand I am entitled to a copy of this document in its complete form. I understand that it is possible that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.

Signature of Patient

Date

Signature of Personal Representative Date
(where required)

Description of Personal Representative’s
Authority