GRAND VALLEY MEDICAL SPECIALISTS, PLC

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated.

Patient Name: ____

SSN (last four digits): ____________________ **Date of Birth:** ____________________

Entity Requested to Release Information: ____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity who is to receive your PHI):

Individual/Entity Name: ____

Relation: ____

Address: ____

Phone/Fax: ______________________ / ______________________

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ office notes

☐ lab results, pathology reports

☐ x-rays

☐ financial history report (previous 3 years only).

☐ nursing home, home health, hospice, and other physician records

☐ record of HIV and communicable disease testing

☐ record of mental health or substance abuse treatment

☐ Only send the following: ______________________

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): ______________________

- This authorization will expire one year from the date signed below, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the date listed below: ____________________
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

____ ____________________

patient or authorized representative signature date

____ ____________________

patient or authorized representative signature date

____ ____________________

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

Limited Patient Authorization for Disclosure of Protected Health Information

This form will give our office the authority to provide your protected health information (PHI) to the person or entity designated on the form. The Limited Patient Authorization limits us to disclose only the information that you designate and does not give any other rights to the person you have named on the form.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information (i.e., our practice).

Purpose of Request- To disclose your protected health information to an individual or entity.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure. If you would like your PHI emailed to the recipient, please provide the email address that you would like us to use, and review the note on the form regarding Secure Communication.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure – Check Patient Request if you are initiating the authorization. Otherwise, the purpose should be stated for you.

Expiration or Termination - This authorization will expire one year from the date in which it was signed unless you specify an earlier termination. The authorization would need to be renewed each year as a means of protecting your information by verifying your wish to continue the authorization.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on completion of this authorization form.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.

© Eagle Associates, Inc. (800) 777-2337