AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize TruCare Internal Medicine & Infectious Diseases to release or obtain Protected Health Information as described below.

Patient Name ______________________ Birth date ____________

Address: ______________________ Fee: ________ Check No. ________ ☐ Cash

______________________ **MR #:** ____________

Authorization is not needed to send your health records directly to or request them from another heath care provider. Reason for Request: ☐ Personal Use ☒ Other (explain) Infectious Disease

Check the boxes next to the information you are requesting. Ask a health care professional for *assistance if needed.*

TruCare will Disclose or Release Only the Information Created by TruCare

Date(s) of Service		☐ Cardio/Pulmonary Report	☐ Laboratory Results	☐ *Mental Health Intake Record*
☐ Face Sheet	☐ Discharge Summary	☐ Progress Notes	☐ Pathology Report	☐ Mental Health Records
☐ Operative Report	☐ Consultation Reports	☐ History & Physical	☒ Complete Record	☐ Psychiatric Evaluation
☐ Other (list)		☐ X-ray/Imaging Report & Data (Specify)		☐ Office Visit Record
				☐ Emergency Depart. Report

Name and address of where the health record is to be sent or obtained from: ☐ **Will Pickup Records**

Name Dr. T. Stainbrook Telephone Number: 814-371-2348

Address 135 Midway Dr. Ste B Fax Number: 814-372-6090

DuBois PA 15801

PATIENT RIGHTS: I understand;

- Signing this authorization is voluntary, and DRMC cannot deny me treatment for not agreeing to sign this authorization. If I refuse to sign the authorization, I understand that DRMC may refuse to provide services (a) that are solely for the disclosure to a third party (b) that are for a health plan's eligibility or enrollment (c) that are research-related and (d) that health plans may condition enrollment on a signed authorization.
- I have the right to withdraw this authorization at any time and I must do so in writing addressed to the Health Information Management Department at DRMC
- The information that has already been released in response to this authorization is not affected by my request to withdraw the authorization
- The withdrawal of this authorization will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy
- DRMC can no longer protect the confidentiality of information released as a result of this authorization
- This authorization will expire in six (6) months unless a specific time frame is documented or I revoke the authorization in writing. I understand that revoking my authorization does not apply to any information released prior to the date on my written request to revoke.

I understand that my medical record may contain sensitive information relating to sexually transmitted diseases (STD), HIV, AIDS, genetic testing, psychiatric/mental health treatment and/or testing and treatment and testing for chemical and/or alcohol use.

☐ I **do not** authorize the disclosure of the sensitive information.

☐ I **do** authorize the disclosure of sensitive information relating to ______________

____

Signature of Patient or Legal Representative (proof of legal representation required) Date

____

TruCare Representative's Signature Date

 Original to Patient Record Copy to Patient or Legal Representative Revised: 04/04 4/05