

Information





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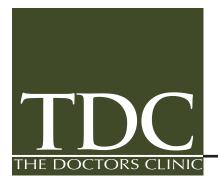
Authorization for Use or Disclosure of Protected Health Information/Access to Protected Health Attachment B

<i>1</i>	, [Print name of Individual (i.e. patient, resident or client)]	
hereby authorize		entity] to use and/or disclose the individua
dentifiable health information as describe	d below for the following patier	nt:
Patient Name:		DOB:
Street Address:		
City:	State:	Zip Code:
authorize the following person(s) or organ	nization to receive the informati	on:
Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	Email:
The following individually identifiable heal	•	
 — All Records — Discharge Summary — Inpatient Records — Emergency Room Records — Complications and Procedures — Abstracts — Immunization (shot) Record Other* 	Outpatient R Consultation History and F Physical Then	ests & X-rays with Final Diagnosis ecords Reports Physical Records

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I request the form of the information be _____Paper ____ Electronic (CD/DVD) ____ Electronic (Email)







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I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

I understand a fee may be charged for copies of my medical record.

Prohibition on Conditioning of Authorization: The Doctors Clinic, a part of Franciscan Medical Group, will not condition treatment on your signing this authorization unless:

- You are receiving research-related treatment, or
- The only reason th efacility is providing you with health care is to make a report to a third party, such as your employer (e.g. fitness to return to work) or school (e.g. P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially re-disclose it. However, under the Federal Sustance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable sustance abuse information.

Expiration: This authorization will expire	(insert date, event or "once purpose stated above is served")	
EXPIRATION: THIS authorization will expire	(IIISELL date, event of tolice pulpose stated above is served)	

Revocation: I understand that I may revoke this authorization at any time by notifying The Doctors Clinic, a part of Franciscan Medical Group, in writing or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that The Doctors Clinic, a part of Franciscan Medical Group, took before it received my revocation letter. For example, The Doctors Clinic, a part of Franciscan Medical Group, cannot rescind disclosures it has already made and may use my health information as necessary to bil and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in The Doctors Clinic, a part of Franciscan Medical Group's Notice of Privacy Practices.

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Information page 3 of 3 SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE Printed name of individual's personal representative, if applicable: Rationale for serving as personal representative to the individual (e.g. parent, legal guardian): FOR INTERNAL PURPOSES ONLY [Insert VMFH Entity] is requesting an authorization to use health When information for its own use, the following provision must be completed: Staff Personnel: Received by: _____ Date: ____ Yes No Was a signed copy provided to the individual? Access approved? ____Yes ____No

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