WIDC

WESTERN INFECTIOUS DISEASE CONSULTANTS, P.C.

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Authorization Obtain or Release My Protected Health Information

Patient name: _____ DOB: _____

I. My Authorization

Release To WIDC:

☐ I give my authorization to obtain my protected health information from:

Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Release From WIDC:

☐ I give my authorization for Western Infectious Disease Consultants, P.C. to release my protected health information to:

Practice Name: _____

Practice Phone: _____ Practice Fax: _____

Email address: _____

Reason for Release: _____

Please check all that apply:

☐ All my protected health information maintained by the above-named practice.

☐ My protected health information relating to: _____

_____

☐ My protected health information for the date(s) of: _____

I specifically authorize disclosure of the following conditions:

☐ Drug Abuse ☐ Alcohol Abuse ☐ HIV/AIDS ☐ Psychological or psychiatric conditions

This authorization ends: On date: _____ OR ☐ One year from date of signing.

II. My Rights

☐ I understand that I may revoke this authorization in writing by writing a letter to the office. If authorization is revoked, it will not affect the actions already in place by the above-named practice based on this authorization. I also understand that once the above-named practice discloses my protected health information, it may be re-disclosed and privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized signature Date Time

_____ _____ _____

Printed name if signed on behalf of the patient Date Time

Office Notes: _____

_____

_____

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