Cone Health Medical Group
Partnering for exceptional care.

MRN: _____

CONE HEALTH MEDICAL GROUP

REQUEST & AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please address revocations or inquiries pertinent to this request to *(site name, address, phone, and fax)*:

PLEASE PRINT

Patient Name: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

READ THE FOLLOWING CAREFULLY:

Cone Health, its employees, officers, and physicians are hereby released from any legal responsibility or liability for the disclosure of the information listed below to the extent indicated and authorized herein. I hereby authorize the use or disclosure of my individually identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse, and HIV/AIDS diagnosis. I understand that this authorization is voluntary. I understand that, if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations.

I understand that unless revoked earlier, this authorization will expire on (*DATE*):_____. If no date is indicated, this release will expire 90 days from the date of signature. I understand that I may revoke this authorization at any time by notifying Cone Health in writing; if I do revoke it will not have any effect on any actions Cone Health took before the revocation was received. I understand that Cone Health cannot make me sign this authorization as a condition to receive treatment from Cone Health except (i) when Cone Health provides me with research-related treatment, or (ii) when Cone Health provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

THERE MAY BE A CHARGE FOR THE REPRODUCTION OF MEDICAL RECORDS/FILMS/TAPES.

The reproduction of my Protected Health Information should be provided in the following manner (check all that applies):
☐ Print on paper ☐ CD/DVD/USB ☐ Mail ☐ Fax to #_____ ☐ Pick up by the authorized recipient

I authorize Cone Health or _____ to disclose the following information to:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

The information is to be disclosed for the purpose of: ☐ Continuity of Care ☐ Legal Representation ☐ School Credit ☐ Patient Request

☐ Other (specify) _____ .

Information to be disclosed:
Dates covering the period(s) of health care from: _____ to _____.

Select from the following (check all that apply): ☐ Dates of Service(s) ☐ Hospital Discharge Summary ☐ History & Physical

☐ Office Progress Notes ☐ Lab Test ☐ X-ray Reports ☐ Other (specify): _____ .

_____ _____
Signature of Patient Date

_____ _____
Signature of: ☐ Parent ☐ Guardian ☐ Authorized Representative *(attach copy of legal documents)* Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

OFFICE USE ONLY:

_____ _____ _____
Driver's License # Staff Signature *(STAFF MUST CHECK LEGAL PICTURE I.D. PRIOR TO SIGNING)* Date

DATE PROCESSED: _____ NUMBER OF PAGES: _____ INITIALS: _____ CHECK ONE: ☐ MAILED ☐ FAXED ☐ PICKED UP