



Mail to: Cedar Valley Medical Specialists, P.C.

Attn: \_\_\_\_\_

### Standard Authorization to Use or Disclose Protected Health Information (PHI)

**Section A: I give my permission to release health information for the individual listed below. Read the following information to make sure that it is correct:**

Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Section B: Office/Physician that will provide this health information:**

**Section C: This information is to be sent to:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

**Section D: Describe the specific Protected Health Information to use or disclose, including date(s):**

**MUST BE COMPLETED BEFORE RECORDS RELEASED**

- Complete Medical Record**[This would include Psychiatric (mental health) information, HIV and/or Aids related diagnosis, evaluation information, and Substance Abuse(Drug or Alcohol) information] Patient has the right to review information disclosed.
- Partial Medical Record – Do not include the following areas of my records in this release:**
  - Psychiatric (mental health) information
  - HIV and/or Aids related diagnosis, evaluation information
  - Substance Abuse (Drug or Alcohol) information

For the following dates of service: \_\_\_\_\_

Describe the reason for the release or request of information: \_\_\_\_\_

At the request of the individual or  Other \_\_\_\_\_

**Section E: I understand that:**

- This authorization is voluntary. I am not required to sign this form. CVMS does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. If I do not sign this form, CVMS will not disclose my health information as requested.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any effect on any CVMS actions before they received the revocation.
- Once my health information is disclosed as requested in this authorization my health information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed.
- Information used as a result of this authorization may not be further disclosed by CVMS without the written authorization of the person to whom it pertains.
- I may receive a copy.

**Section F: Signature**

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the individual listed in Section A. This authorization will expire in one year.

Signature of Individual/Individual's Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Section G: If Section F is signed by a Personal Representative, please complete the information below:**

Personal Representative's Name: \_\_\_\_\_  
Relationship to Individual: \_\_\_\_\_  
Personal Representative's Address \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_  
Personal Representative's Area Code & Telephone Number: \_\_\_\_\_

Date Sent: \_\_\_\_\_ Initials: \_\_\_\_\_  
Faxed to: \_\_\_\_\_ Picked up by pt: \_\_\_\_\_ Mailed to: \_\_\_\_\_