

**Summit Community Care Clinic  
 AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED  
 HEALTH INFORMATION – MEDICAL NOTES  
 (HIPAA Release Form)**



**COMPLETE ALL SECTIONS, DATE, AND SIGN**

I, \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ hereby voluntarily authorize the disclosure of information from my health record.

<b>Release information FROM:</b>	<b>Release information TO:</b>
Name of Facility:	Name of person/organization/facility:
Address:	Address:
Phone number/Fax	Phone Number/Fax:

**The purpose or need for this disclosure is:**

Further Medical Care:	Attorney:	Disability:	Personal Use:	Insurance:
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**Dates of Service** \_\_\_\_\_

**The information to be disclosed from my health record, initial the applicable box(es) below:**

Clinic notes:	EKG's:	Labs:	Radiology reports:
History and physical:	Immunization records:	Pathology Reports:	Billing:

**If you would like any of the following sensitive information disclosed, initial the applicable box(es) below:**

Alcohol/Drug Abuse Treatment/Referral:	HIV/AIDS-related Treatment:	Sexually Transmitted Infections:	Behavioral Health Clinical Summary:
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- I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it.
- Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization.
- I may be charged for copies in accordance with state law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
- This authorization will expire **one year** from the date of signing unless I indicate an earlier or earlier date here: \_\_\_\_\_

**ATTENTION:**

This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and **include written documentation of your relationship** (Circle):

Legal Guardian      Conservator      Health Care Agent (Health Care Power of Attorney)

- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship (circle): Parent      Legal Guardian      Emancipated Minor

Signature (required): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name (required if not patient): \_\_\_\_\_

Mailing Address of Patient: \_\_\_\_\_

SCCC Staff: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_