SELMA MEDICAL ASSOCIATES, INC. - Health Information Management
104 SELMA DRIVE, WINCHESTER, VA 22601
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INTERNAL MEDICINE - INFECTIOUS DISEASE - CARDIOLOGY- FAMILY PRACTICE

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Request: _____

Date of Birth:_____ Medical Record Number:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Selma Medical Associates, Inc.
104 Selma Drive
Winchester, VA 22601

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

X Other **Any and all medical and billing information as needed to help care for patient and to help take care of appointments. Copies of records require additional authorization.**

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Person Name: _____

Relationship: _____

Person Name: _____

Relationship: _____

Person Name: _____

Relationship: _____

Person Name: _____

Relationship: _____

for the purpose of:

helping in taking care of the patient and to have access to medical and billing information as well as appointment information.

(OVER ⇒)

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____**Indefinite**_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Health Information Manager/Privacy Officer
(540) 678-2814 -Voice
(540) 678-2859 -Fax

_____
Signature of Patient or Legal Representative Date

_____
If signed by Legally Appointed Representative, Relationship to Patient

_____
Signature of Witness Date

<u>ALL ITEMS MUST BE COMPLETED OR FORM WILL BE RETURNED</u>

FOR OFFICE USE ONLY:

Date Request Received: _____ Prepayment Requested: _____
Date
Prepayment Received: _____ Records Sent: _____
Date Date
Employee: _____
Name of Employee Handling Request