



**AUTHORIZATION FORM FOR DISCLOSURE/RELEASE OF PROTECTED HEALTH INFORMATION (PHI)  
GENERAL HEALTH INFORMATION/DRUG/ALCOHOL/HIV RELATED INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. I hereby authorize PriMed LLC to:

Release to: \_\_\_\_\_

Receive information from the health record of the above named patient from:

Name/Organization of recipient: \_\_\_\_\_

Address of Recipient: \_\_\_\_\_

2. The purpose for such information: \_\_\_\_\_

3. Requested data:

All Records       Immunization

School/Camp Physical       Other, Specify: \_\_\_\_\_

4. Approximate dates: \_\_\_\_\_

5. This form serves the dual purpose of a general authorization for the release of protected health information and a specific authorization for the release of information protected by state and federal confidentiality laws and regulations. The information to be released may contain information pertaining to mental status, alcohol, drug and/or HIV or AIDS testing, diagnoses or treatment.

6. I understand there may be a .65\$ per page copy fee charged with certain requests for my health information. I have 30 days to receive a copy of my records unless otherwise specified.

7. I understand that it is my right as stated in the PriMed LLC Notice of Privacy to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit this to PriMed LLC. I understand this revocation will not apply to the information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire upon the earlier of 60 days from today's date or a specific date, event or condition to such revocation.

8. I understand authorizing the disclosure of this health information is voluntary. I need not sign this authorization to ensure treatment, payment, or healthcare operations. I understand I may inspect/copy the information to be used or disclosed according to state and federal law, and as stated in the Privacy Notice of this facility. I understand information once released from this facility may not be protected by federal confidentiality rules and carries with it the potential for an unauthorized re-disclosure.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
If Legal Representative, specify relationship

\_\_\_\_\_  
Date

The patient is a minor \_\_\_\_\_ years of age

Patient or legal representative requested this authorization be revoked.  
Do not comply with this request effective this date:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Recorded by PriMed Staff (Name)