NEWTOWN INTERNAL MEDICINE
A Functional and Holistic Approach

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HIPPA PROTECTED HEALTH INFORMATION

This is an optional form, which only needs to be completed if you would like Newtown Internal Medicine to release and disclose your protected health information ("PHI") to a relative, partner or friend.

I, _____, authorize the release and disclosure of the
(print your name)
protected health information ("PHI") described below to _____.
(print name)
He/she is my _____.
(relation to you/patient)

CHECK OPTION (1) OR (2):

- o (1) This authorization for release of information covers only the period of healthcare:

  From: ____/____/____ To: ____/____/____

  OR

- o (2) All past, present and future periods

CHECK OPTION (a) OR (b):

- o (a) I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment for alcohol and/or drug abuse).

  OR

- o (b) I authorize the release of my complete health record, with the exception of the following information:
  - o Mental health records
  - o Communicable diseases (including HIV and AIDS)
  - o Alcohol/drug abuse treatment
  - o Other (please specify): _____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in effect:

- o indefinitely OR
- o until ____/____/____, at which time this authorization expires.

_____ ____/____/____
Signature of Patient / Patient Representative / Legal Guardian Date of Birth (Patient)

_____ ____/____/____
Print name of person signing this Form Today's Date

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