AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Health Record Number _____
Date of Birth: _____ SS No.:_____
Patient Account No._____

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:
   Provider Name:
   Provider Address:

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - □ problem list
   - □ medication list
   - □ list of allergies
   - □ immunization record
   - □ most recent history and physical
   - □ most recent discharge summary
   - □ laboratory results from (date) _____ to (date)_____
   - □ x-ray and imaging reports from (date) _____ to (date)_____
   - □ consultation reports from (doctors' names) _____
   - □ entire record
   - □ other: _____

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:

Abrams, Landau Ltd., 797 Center Street, Herndon, Virginia, 20170

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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: _____. 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 assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness