AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND HEALTH INFORMATION

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____

II. **AUTHORIZATION**. I authorize Brandon Richland MD Inc and associates/employees (hereinafter known as "Authorized Party" to release all of my medical records and medical information to the party in Section III Disclosure below.

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: **(check one)**

☐ - Any party that is approved by the Authorized Party

☐ - <u>ONLY</u> the following party:

Name: _____

Address: _____

Phone: _____

Fax: _____

E-Mail: _____

☐ - <u>SELF</u>

IV. **ACKNOWLEDGMENT OF RIGHTS**.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Print Name: _____

Signature of Patient or Authorized Guardian: **_____**

Date: _____