ADAPS HEALTHCARE

AUTHORIZATION TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION

Patient Name: _____ DOB: _____ Telephone**:** _____

Address: _____

I hereby authorize ADAPS HEALTHCARE (the "Practice") to release the medical information requested to the individual/organization named below not including any category of additional protected information unless I have initialed this form below.

Furnish to: _____

Address: _____

Treatment Dates: _____ Purpose of Request: _____

Information Requested:_____

_____

1. **If my initials appear here_____,** I specifically authorize release of my mental health records and information, including any communications between me and my psychiatrist, psychologist, or other behavioral health professional.

2. **If my initials appear here_____,** I specifically authorize release of my HIV, AIDS, or ARC information

3. **If my initials appear here_____,** I specifically authorize release of my records that contain information about venereal disease(s), sexually transmitted disease(s), abortion consents or records, family planning services, and/or genetic testing.

4. **If my initials appear here_____,** I specifically authorize release of my records concerning sexual assault treatment.

5. **If my initials appear here_____**, I specifically authorize release of information about drug or alcohol abuse treatment.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to the Practice. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I further understand that once the above information is disclosed it may be re-disclosed and no longer protected by federal or state privacy laws or regulations. I hereby release the Practice, its professionals, employees and agents from all liability from this authorized disclosure of my health information.

Unless otherwise revoked this authorization will expire on the following date, event or condition, or within one year: _____

I further understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment. If information is requested by my health insurer and I refuse to sign a required authorization, I understand that the health insurer may in certain circumstances deny payment, enrollment or eligibility for benefits. I understand that I may inspect or request copies of any information disclosed by this authorization as allowed by law.

Date: _____ Signature of Patient or Representative: _____

If signed by a Personal Representative, please describe authority or relationship: _____