UNITY FAMILY MEDICINE
615 E. Fulmer Road, Mishawaka, IN 46544
574-252-3085 Fax: 574-252-5906

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone #: _____

Authority to Release Protected Health Information

I hereby authorize **"UNITY FAMILY MEDICINE" OR "ANY ENTITY THAT IS AUTHORIZED TO RELEASE INFORMATION ON BEHALF OF UFM** to release the information identified in this authorization form from the medical records of _____
and provide such information to _____.

Information to be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Complete health record	☐ Consultation reports	
☐ History & physical exam	☐ X-ray reports	
☐ Laboratory test results	☐ Medication records	
☐ Other diagnostic tests results		

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"):

_____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and /or other sensitive information, I agree to its release. ***Check one*:** ☐ **Yes** ☐ **No**

I understand if my medical or billing record contains information in reference to HIV/Aids (Human Immunodeficiency virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. ***Check one*:** ☐ **Yes** ☐ **No**

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to 4455 Edison Parkway, Mishawaka, IN 46545. Unless revoked, this authorization will expire six (6) months from the date of request.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Requesting Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby release and discharge UNITY MEDICAL AND SURGICAL HOSPITAL of any liability and the undersigned will hold UNITY MEDICAL AND SURGICAL HOSPITAL harmless for complying with this Authorization.**

Signature: _____ **Date:** _____

Description of relationship if not Patient: _____

Notice of Confidentiality: This form may contain information that is personal, privileged and/or confidential. If you are in receipt of this form and are not the intended recipient, or if you receive this form in error, please contact us by telephone immediately and destroy all documents.