Patient Authorization for Use and Disclosure of Protected

Health Information to the Practice from another Practice

Memo To:

_____

(Name of Doctor, Practice, Hospital, Clinic or other Health Care Provider)

_____

(Address City, State, Zip)

Memo From:

_____

(Name of Patient Information is being Requested For/ Date of Birth)

_____

(Address City, State, Zip)

My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you to forward copies of my record:

By signing this authorization, I request and authorize you to release certain protected health information (PHI) about me to:

Inspired Health Group
3671 Southwestern Blvd., Suite 101
Orchard Park, New York 14127

This authorization permits you to use and /or disclose the following individually identifiable health information about me (specifically describe the information to be released, such as date (s) of services, type of services, level of detail to be released, origin of information, etc.):

All recent progress notes, diagnostics and immunization records.

The following information will not be released unless specifically requested by initialing the item:

____Chemical Dependency records (records relating to alcohol or substance abuse)

____Mental health records (including any care for anxiety or depression)

____HIV related information (signed NYS form 2557 required)

- The information will be used or disclosed for the following purpose: Further medical care.
- This authorization will expire in 90 days. This disclosure can be revoked at your request.
- When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above.

Signed by:

_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient
_____	_____
Patient's Name	Date
_____	_____
Print Name of Patient or Legal Guardian	Date of Birth