

AUTHORIZATION TO RELEASE VERBAL MEDICAL INFORMATION TO PERSONS INVOLVED IN MY CARE:

Name of Patient (Please Print) _____ Clinic Record Number: _____

Date of Birth: _____ Daytime phone: ~~XXXXXXXX~~ _____

I hereby give the Springfield Clinic, LLP my permission to release my medical information to the individuals specified below, upon their request. Methods of release may include verbal discussions or updates about my treatment, medications, or condition as requested. The purpose for these disclosures is to enable the persons below to assist me in maintaining my health, and to participate in my medical care.

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

The patient or the patient's representative must read and initial the following statements:

1. I understand that I may see and receive a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____
2. **The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse, infectious diseases including HIV, elective cosmetic procedures, and medical correspondence. If you do not wish such information to be released, do not complete this form. Inform the Receptionist of your decision, to verify and revoke any prior authorizations.** Initials: _____
3. I understand that I may revoke this authorization at any time by notifying the Springfield Clinic in writing, but the revocation will not effect any actions which they have taken prior to the receipt of the revocation. Without express written revocation directed to the Springfield Clinic, I understand that this authorization will not expire during the remainder of my treatment period with the Springfield Clinic, and until such time as I present Springfield Clinic with a revocation of authorization, or complete a new authorization form. Initials: _____
4. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization authorized to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure. Initials: _____

Signature of patient or patient's legal representative Date

(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to patient: _____

NOTE TO PATIENT:

Based on this completed form, the above-specified individuals will be allowed to obtain your health information verbally from any Springfield Clinic facility (with the exception of Behavioral Health Services). NOTICE TO SPRINGFIELD CLINIC EMPLOYEES AND PROVIDERS: Clinic policy prohibits direct access to the information specified above. Contact the provider office for verbal medical information and Patient Accounting for verbal financial information. This authorization does not entitle any party to direct medical system access or to hard copy records for this patient.

Facsimile reproductions of the signature are acceptable.