Carnett Clinic, LLC

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Carnett Clinic LLC has a legal and ethic responsibility to maintain patient privacy, including obligations to protect and confidentiality of patient information and safeguard the privacy of patient health information (PHI).

Name:_____ Date of birth:_____

Address:_____ Telephone number:_____

_____

By signing this authorization, I authorize _____
Physician name, Clinic name, Company name

_____
Phone or fax number or Address

To use and/or disclose certain PHI pertaining to me…

To: _____ OR Person Authorized to Receive Information:

Address: _____ _____

_____ Relation:_____

(Please check all that apply)
__All Medical Records (to include all below except billing record)
__Billing Records
__Mental Health
__Drug and Alcohol Treatment
__Communicable Disease related information
__Other:_____

Purpose For Release:
__At my request
__I am changing doctor
__Insurance Change
__Moving (new address)_____

This authorization will expire one year from the date of signature.
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time in writing.

Signed:_____ **Date:**_____
(Parent or Legal representative)

Signed:_____ **Date:**_____
(Witness)