



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB:** _____ **MRN:** _____

Patient Phone: _____

I authorize the use or disclosure of the above-named individual’s MNA health information as described below.

- The type and amount of information requested or to be disclosed is as follows (check all being requested):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Problem list | <input type="checkbox"/> Medication List | <input type="checkbox"/> Allergy List | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> History and Phys. | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Hospital Recs | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Entire Record | <input type="checkbox"/> Other _____ |

- Dates of Records Requested: **From Date:** _____ **To Date:** _____

- The purpose of the requested use or disclosure is: Patient Use Coordination of Care Legal Request
 Other: _____

Requesting From: _____ Name/Practice: _____ Address: _____ Fax: _____ Phone: _____	Send To: _____ Name/Practice: _____ Address: _____ Fax: _____ Phone: _____
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- Please provide/send my records in the following manner: _____
- I understand that the information in my health record may include information relating to ***Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV)***. It may also include information about behavioral or mental health services, and lab results or treatment for alcohol and drug use. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the MNA Privacy Officer or his/her designated person. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
- If I fail to specify an expiration date, event or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the MNA Privacy Officer at 704-332-0396.

Signature of Patient or Legal Representative

Date

If Legal Representative, Relationship to Patient