GET WELL CENTER

Authorization to Use or Disclose Protected Health Information

Patient name:_____

Date of Birth:_____Phone :_____

Address:_____

City:_____ State:_____ Zip:_____

The following individual or organization is authorized to make disclosure of my protected health information.
(Name of facility or doctor that retains your medical records)

Name or Facility:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

The type of information to be used or disclosed (include dates where appropriate)
(Please initial)
Complete Health records _____ Lab/ X-ray reports_____

Consultation notes_____

Other _____(please specify)_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment. (Please initial) _____

My protected health information may be disclosed and used by the following individual or organization.

Name: Get Well Center/ J.C. Penhos, MD

Address: 635 S. Trimble Rd.,Mansfield, OH 44906

Phone: 419-524-2676 Fax: 419-524-2692

For the purpose of : Continuity of Care

I have read this form and agree to the uses and disclosure of information. I have the right to refuse to sign this form. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is permitted by law. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

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 health information management department. 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: one year from date of signature.

_____ _____

Signature of Patient/ Legal Guardian *Witness (Optional)*

_____ _____

Date *Date*