Authorization for Astar Medical Group to Use or Disclose My Health Care information

Patient Name:_____ **Date of Birth:**_____

Social Security Number:_____ **Previous Name:**_____

I. My Authorization:

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition:
  _____
- ☐ Health care information in my medical record for the date(s):_____
- ☐ Other(e.g., X-rays, bills, labs), specify date(s):_____

Youmayuseordisclosehealthcareinformationregardingtesting,diagnosis,andtreatmentfor(checkallthatapply):

- ☐ HIV(AIDS Virus)
- ☐ Sexually Transmitted Diseases
- ☐ Psychiatric Disorders/Mental Health
- ☐ Drug and/or Alcohol Use

You may disclose this information to:

Purpose(s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Other(specify):_____

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- ☐ In 90 days from the date signed
- ☐ On(date):_____
- ☐ When the following event occurs:_____
  (No longer than 90 days from date signed)

II. My Rights

I understand that Physicians @ Home may not base treatment or payment decisions on whether or not I sign this authorization. I understand I have the right to inspect or receive a copy of my protected health information and to receive a copy of this signed form.

I acknowledge that I have the right to revoke this authorization in writing by either:(1)filling out a revocation form available from Physicians @ Home or(2) sending my revocation via letter to Physicians @ Home to the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

_____ _____

Signature of patient or legally authorized representative Print name

_____ _____

Authority or relationship to individual, if representative Date Time