Release of Medical Information

Restoration
OSTEOPATHIC MEDICINE

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

Restoration Osteopathic Medicine limits the release of protected health information (PHI) to that permissible by patient confidentiality laws. According to HIPAA guidelines, permitted reasons for release of PHI include treatment, payment, scheduling and healthcare operations, or as otherwise allowed by the **explicit signed authorization** of the patient or authorized representative.

Permission to Leave a Detailed Message:
I hereby permit medical providers and staff of Restoration Osteopathic Medicine to leave a detailed message at the following pho**ne number:**_____ and/or e-m**ail address:** _____

☐ **I Decline. Please do not leave me detailed messages.**

Permission to Verbally Discuss PHI with Family Members/Caregivers:

I hereby authorize medical providers and personnel of Restoration Osteopathic Medicine to discuss my protected health information with the following person(s):

Name/Phone number: _____ **Relationship:** _____

Name/Phone number: _____ **Relationship:** _____

Name/Phone number: _____ **Relationship:** _____

☐ **I Decline. Please do not discuss my care with anyone other than as permitted by HIPAA regulations.**

The following information cannot be released without authorization as required by state or federal law. **By initialing the lines below, you authorize the release of the following protected or sensitive material:**

_____ Information regarding the diagnosis and treatment for HIV/AIDS

_____ Psychotherapy notes regarding mental health

_____ Treatment for alcohol or drug abuse

- This authorization will expire 730 days (2 years) from the date of signing.
- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.
- This form is not valid unless signed and dated.

_____ _____

Signature of Patient/Personal Representative **Date**