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AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws including the Health Insurance Portability and Accountability Act of 1996 (HIPPA) governing the use and disclosure of Protected Health Information (PHI).

I hereby authorize Susan P. Epner, M.D. to ☐ disclose/release to ☐ obtain from

Name of Person or Organization: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by HIPPA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice in writing to the Privacy Offices. Unless revoked this authorization will expire one year from the date of my signature or on the following date _____. If I choose to limit the information released I understand that Susan P. Epner, M.D. may inform the requestor that portions of the records have been withheld. I understand the information disclosed may be subject to redisclosure by the recipient and no longer be protected by Susan P. Epner, M.D. Susan P. Epner, M.D. and her staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

☐ ALL medical records without exception, including: clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease, consultations, secondary records, etc. or:

☐ PARTIAL medical records which may include HIV testing and treatment, mental health treatment, alcohol or drug abuse testing and treatment, sexually transmitted disease and other sensitive information. Please specify parts and dates to be released:

☐ consultations _____
☐ progress notes _____
☐ MRI/CAT scan _____
☐ x-ray reports _____
☐ lab reports _____
☐ physical _____
☐ allergy _____
☐ other (specify) _____

I authorize the release of my medical records as indicated above.

_____ _____
Signature of patient or legal guardian Social Security Number

_____ _____
Printed Name Date of Birth

_____ _____ _____ _____
Address City State ZIP

_____ _____
Telephone number Date

_____ _____
Previous name under which records may be found Witness Date

Note to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws (including HIPPA) and prohibits you from further disclosure without the written consent of the person to whom it pertains. Charges may apply for copies of medical records. A copy of this form will be filed in the above named patient's PHI.