HEART OF AMERICA
MEDICAL CENTER

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Authorization to Disclose Clinical/Financial Information

The privacy of the patient's protected health information is very important to Heart of America Medical Center. The Patient had the authority to control access to and disclose of protected health information except for those disclosures that are allowed without patient authorization (as listed in the Notice of Privacy Practices).

Patient Name: _____ Phone Number: _____

Date of Birth: _____ Social Security Number:_____

In filling out this form, I hereby request that:

☐ Clinical information (i.e. test results, clinical findings, and care decisions) only

☐ Financial/billing information only

☐ Clinical and financial information

Can be discussed or shared with the following persons:

Name: _____ Name: _____
Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

This authorization to disclose information to the designed individuals also includes the indicated sensitive records:

Mental Health_____ Initial_____ Date_____
Substance Abuse_____ Initial_____ Date_____
HIV/AIDS_____ Initial_____ Date_____

☐ My authorization is not limited to a certain time-period or visit date.

☐ Limited authorization for the following time-period or visit date (s):_____

☐ The Authorization shall be in effect for 12 months following the date of signature.

Revocation: I understand that this authorization will remain in effect until such time that I revoke it in writing to Heart of America Medical Center Privacy Officer or designee.

_____ _____

Patient/Patient Representative Signature **Date**

_____

Print Name