UNITED MEDICAL CLINIC

Bear
121 Becks Woods Dr.
Suite 100
Bear, DE 19701
Fax (302) 836-4302

Dover
1113 S. State Street
Suite #202
Dover, DE 19901
Fax (302) 836-4302

Smyrna
38 Deak Drive
Smyrna, DE 19977
Fax (302) 653-9563

Wilmington
1021 Gilpin Ave.
Suite 203
Wilmington, DE 19806
Fax (302) 836-4302

Patient Authorization for Disclosure of Health Information (1)

Patient Name: _____Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate Phone: _____

I request that my protected health information (PHI) from United Medical Clinic LLC. Be disclosed to:

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s): Emergency Room Record Laboratory Report(s) Radiology Report(s) Pathology Report Immunization Record Abstract/ Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations, and Test Results), Itemized Billing Records,
Other:_____

Covering the period of healthcare from: Specific Date(s): _____ to _____ or All Medical Records

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. **If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):**

Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____
HIV Testing and Results □ Yes □ No Dates: _____

Mental Health □ Yes □ No Dates: _____
Psychotherapy Records □ Yes □ No Dates: _____

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other (please specify other on line below):

_____

_____

Disclosure Method: US Mail, Fax (healthcare provider only), CD– secure format, other (please specify): (Photo ID needed for pick up) _____

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Patient Authorization for Disclosure of Health Information (2)

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I understand that I may inspect a copy of the records being disclosed.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at one of the following addresses written above. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition:

_____.

If I fail to specify an expiration date/event/condition, this authorization will expire in 3 months from the date and signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- Marketing: Financial remuneration has been received by a third party for marketing purposes.
- Sale of PHI: Remuneration is received for disclosure of my health information.
- I understand that there may be a fee for copying or supplying medical records. (Fee schedules are set forth by State)

_____

Patient or Authorized Representative Signature Date

_____

Print Name Relationship to Patient (if applicable)

Note: A minor's signature is required for release of information related to reproductive care, sexually transmitted diseases, and drug alcohol or substance abuse and mental health treatment.

Minor's Signature: _____ Date: _____