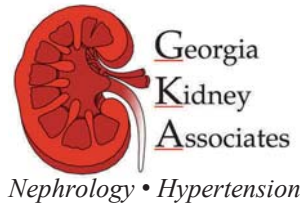


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Marietta Miller, Administrator

**Discovery Health Record Solutions • Authorization to Use or Disclose Protected Health Information (PHI)**

I hereby authorize \_\_\_\_\_ to release information from the records of :

\_\_\_\_\_  
Name of Patient : \_\_\_\_\_ Date of Birth : \_\_\_\_\_ Last four Digits of SSN \_\_\_\_\_

This information is to be released to: \_\_\_\_\_

Records are being required for the purpose of: \_\_\_\_\_

Types of records to be released and approximate dates of service (check all that apply and treatment dates):

Outpatient Records: \_\_\_\_\_ Physician Offices/Clinic: \_\_\_\_\_

The following medicals records are to be released (check all that apply):

**ENTIRE MEDICAL RECORD (Includes all sections mentioned below):**

- |  |  |
|--|--|
| <input type="checkbox"/> Billing Statements            | <input type="checkbox"/> Medical History/Physical Exam |
| <input type="checkbox"/> Care Plans                    | <input type="checkbox"/> Medication Records            |
| <input type="checkbox"/> Clinician office notes        | <input type="checkbox"/> Progress Notes                |
| <input type="checkbox"/> Consultant Reports            | <input type="checkbox"/> Operative Report              |
| <input type="checkbox"/> Discharge Summary             | <input type="checkbox"/> Pathology Report              |
| <input type="checkbox"/> EKG Reports                   | <input type="checkbox"/> Physician Orders              |
| <input type="checkbox"/> Emergency/Urgent Care Records | <input type="checkbox"/> Psychiatric Evaluations       |
| <input type="checkbox"/> Labor and Delivery Records    | <input type="checkbox"/> Psychiatric Records           |
| <input type="checkbox"/> Laboratory Reports            | <input type="checkbox"/> Radiology Reports             |
| <input type="checkbox"/> Mammography Report            |  |
| <input type="checkbox"/> Other _____                   |  |

HIV, Mental Health, and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:

HIV  Mental Health (Psychiatric)  Drug & Alcohol

This authorization will expire in 1 year unless I otherwise indicate here: \_\_\_\_\_

**My signature below indicates that: I have read and understood this information: I can request to receive a copy of this form. I am the patient, and/or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated forms. Please see below for additional patient rights and responsibilities.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

Patient Email Address (required for electronic delivery/please print clearly): \_\_\_\_\_  
(DHRS will send patient email to set up with electronic delivery to patient through StatusNOW tracking system)

Representative's Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Representative's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **Additional Patient Rights and Responsibilities**

- Treatment cannot be withheld if the patient refuses to sign the Authorization.
- The law requires that a disclosure statement will accompany medical records.
- The form dictates what records will be released, and for what purposes; no items will be released if they have not been listed or otherwise indicated on this form.
- Discovery health Record Solutions is neither liable nor responsible for any re-disclosure of records once they are received by the organization/person/facility that makes the request.
- A patient may revoke this authorization at any time by sending a written request to the entity authorized to release the information.
- A patient's decision to revoke the Authorization is not retroactive; it does not apply to any release of his or her records which may have taken place prior to the date of the revocation of the Authorization.
- The decision to revoke the Authorization may result in the patient's insurance company's not being able to authorize payment for medical care: It must be understood that the patient may be responsible for payments of any and all claims filed.
- The patient is entitled to a copy of his or her completed Authorization form.
- A faxed copy of this authorization shall serve in lieu of the original.