Authorization for Use or Disclosure of Health Information

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Name: ____________________________
Date of Birth: ____________________________

I hereby authorize Robin Knuttel, MD to release my records to:

Name: ____

Address: ____

City, State, Zip: ____

Phone/ Fax Number: ____

The following information is to be released:

- ☐ Clinical Notes- Date(s) of Service: _________________________
- ☐ Lab Tests- Date(s) of Service: _________________________
- ☐ Entire Record Date(s) of Service: _________________________
- ☐ Other (please specify needed information and date(s) of service if known): _______________
  ____

Patient's Initials

_____ I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above.

_____ I realize that the office and its employees have a responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The office will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Robin Knuttel, MD and the employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

The purpose of the release of this information is:

- ☐ Insurance or other third party reimbursement
- ☐ Continuity of medical care
- ☐ Pending legal action
- ☐ At the request of the patient
- ☐ Other: (Specify) ____

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RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: 181 Andrieux Street, Ste. 103; Sonoma, CA 95476.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

Patient's Signature:____ Date: ______________________
(or parent if patient is a minor)
Patient's Address:

If signed by someone other than the patient, state your legal relationship to the patient:
____
____

Signature of Witness: ____

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