Authorization for Release of Protected Health Information (PHI)

Patient Name (Records to be released): _____

Street: _____

City, State, ZIP code: _____

Date of Birth: _____

1. **Records** to be disclosed:

   ☐ Complete medical history ☐ Lab reports ☐ Immunization history ☐ Itemized billing

2. **Sensitive Records** to be disclosed (must select at least one option):

   ☐ Sexually Transmitted Diseases/Infections lab reports ☐ Behavioral Health

   ☐ Request excludes sensitive records

3. **Dates of Service** to be disclosed: ☐ ALL Dates of Service

   ☐ Specific Dates of Service: _____

4. My Records may be disclosed **to the following person or company:**

   Person or Company Name: _____

   Mailing Address/Email Address: _____

5. I authorize MinuteClinic to disclose my Records **for the purpose of:**

   ☐ At the request of Patient or Patient's Personal Representative (no specific purpose)

   ☐ Specific Purpose: _____

6. This Authorization **will expire 6 months** from the date I sign it as shown below unless I enter a different expiration date here: _____/_____/_____

7. **By signing below, I understand and agree that:**

   - My Records may include sensitive information related to the treatment of mental health conditions, alcohol or substance abuse, sexually transmitted diseases like HIV/AIDS or other communicable and non-communicable diseases, and genetic marker information.
   - I may revoke this authorization at any time by writing to MinuteClinic at the address, email or fax number listed at the bottom of this form, except to the extent that MinuteClinic has taken action in reliance on this authorization.
   - I understand that signing this authorization is voluntary and that this authorization will not affect my ability to obtain treatment, payment for treatment or enrollment or eligibility for benefits for MinuteClinic. A photocopy or facsimile of this signed Authorization is as valid as the original and will be accepted.
   - Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI.
   - I understand that I have the right to receive a copy of this Authorization.

_____ _____

Signature of Patient/Personal Representative* Date

*****_If signed by someone other than the patient, please print your full name, explain your authority to act on behalf of this patient, and provide us paperwork evidencing this authority (e.g. Power of Attorney or Guardianship form):_

_____

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