TODD R. FISHER M.D. FAMILY MEDICINE

300 E. Main Street, Hummelstown, PA 17036
Phone: 717-566-1100 - Fax: 717-566-0600

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

This authorization gives permission to use or disclose health information about you.

Patient Name: **Date of Birth:**

Social Security #:

Address:

Home Phone #: **Mobile Phone #:**

1. **Source:** *The following individual(s) or organization(s) are authorized to disclose the health information of the above named individual as described in this authorization:*

Physician Name:

Address:

Phone #: **Fax #:**

2. **Recipient:** *The covered health information may be used by or disclosed to the following individual(s) or organization(s):*

Physician Name: **Todd R. Fisher MD Family Medicine**

Address: **300 E. Main Street, Hummelstown, PA 17036**

3. **Covered health information:** *The following health information is covered by this authorization (except as limited below):*

☐ Complete Medical Record (past 2 years including Immunization records, Laboratory Studies, MRI's, CT scans, X-rays, EKGs, Mammograms, Pap Smear if applicable.

☐ Other (please specify):_____

_____

4. **Purpose:** *I am requesting use or disclosure of the covered health information for the following purpose:*

☐ Transfer of Care

☐ Personal Use

☐ Other (please describe):_____

_____

5. **Expiration:** *This authorization expires in 60 days:* _____

6. **Specially protected information must be completed:** *The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released:*

► Substance abuse records (drug or alcohol): ☐Yes ☐No Initials: _____

► Mental health records protected by the Mental Health Procedures Act: ☐Yes ☐No Initials: _____

► HIV/AIDS related information: ☐Yes ☐No Initials: _____

7. Other restrictions: *Please specify any other restrictions on your covered health information:*

► Date(s) of Restriction: _____

► What information should not be disclosed: _____

_____

► Who is the information restricted from: _____ _____

_____

8. Rights:

► **Right to revoke:** *You may revoke this authorization at any time. Your revocation will not apply to any actions which have already taken in reliance on this authorization. To revoke this authorization, please submit a written request to privacy officer at following address:*

Todd R. Fisher MD Family Medicine
Attention: Nancy E. Fisher, Office Manager
300 East Main Street
Hummelstown, PA 17036

► **Re-disclosure:** *I understand that once the covered health information has been disclosed, it may no longer be protected by privacy laws and may be re-disclosed by the recipient.*

I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.

_____ _____
Signature of Patient (or personal representative) Date

_____ _____
Name of Personal Representative Relationship to Patient