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DISCLOSURE OF PROTECTED HEALTH INFORMATION

AUTHORIZATION I authorize: Jeanette Walker, MD at New Focus Health, PC, to disclose the specific health information described below regarding:

____

(patient's name) (date of birth)

consisting of:

_____ Physician notes and records

_____ Lab test results

_____ Imaging reports

_____ Other information: ____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information

_____ Mental health information

_____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to re-disclosure.

I request that the above initialed information be released to (other health care provider or third party):

Name: ____

Address: ____

Phone: ____

I may revoke this authorization at any time by notifying Physician in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Physician before Physician received my written notice of revocation.

I may request to inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form if such request is received in writing to Dr. Walker. This Authorization is voluntary, and I may refuse to sign this Authorization form.

***I have read this authorization and I understand it. Unless revoked, this authorization remains in effect until I revoke it in writing*.**

____

Signature of patient (or legally responsible person- state relationship to patient) Today's Date