Borealis Heart Specialists Medical Release/Request Form

Patient Authorization for Use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your individually identifiable health information without your authorization, except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the use and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

Patient Name (print): _____ **DOB:** _____ **Phone #:** _____

- ☐ I hereby authorize, Borealis Heart Specialists to **release** health information on the patient named above:
- ☐ I hereby authorize, Borealis Heart Specialists to **receive** health information on the patient named above:

I authorize the release of (please initial):

- ☐ **ALL** of my health information
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the following date(s) of service: _____
- ☐ Other: _____

Reason for Release (must be noted): _____

Release Medical Records To/From:_____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Restrictions: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE INITIAL all requested INCLUSIONS (okay to be sent):

___Alcohol/Drug ___Behavioral/Mental Health/Psychiatric ___Sexually Transmitted Disease ___HIV/AIDS

___Other (please specify): _____

This authorization is Effective: **Date** _____ **through** _____ **(**dates must be specified)

SIGNATURE: _____

PRINT NAME: _____ **DATE:** _____

Patient/Guardian/Parent/Patient's Representative

I understand that I may revoke this authorization at any time by notifying Borealis Heart Specialists in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt. I understand that if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal Laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.