



Mail to: Cedar Valley Medical Specialists, P.C.

Attn: _____

Standard Authorization to Use or Disclose Protected Health Information (PHI)

Section A: I give my permission to release health information for the individual listed below. Read the following information to make sure that it is correct:

Name: _____
Social Security Number: _____ Date of Birth _____ Telephone Number _____
Address: _____ City: _____ State: _____ Zip: _____

Section B: Office/Physician that will provide this health information:

Name: _____
Address: _____

Section C: This information is to be sent to:

Name: _____
Address: _____

Section D: Describe the specific Protected Health Information to use or disclose, including date(s):

MUST BE COMPLETED BEFORE RECORDS RELEASED

- Complete Medical Record**[This would include Psychiatric (mental health) information, HIV and/or Aids related diagnosis, evaluation information, and Substance Abuse(Drug or Alcohol) information]
- Partial Medical Record – Do not include the following areas of my records in this release:**
 - Psychiatric (mental health) information
 - HIV and/or Aids related diagnosis, evaluation information
 - Substance Abuse (Drug or Alcohol) information

For the following dates of service: _____

Describe the reason for the release or request of information: _____

At the request of the individual or Other _____

Section E: I understand that:

- This authorization is voluntary
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any affect on any CVMS actions before they received the revocation.
- Information used as a result of this authorization may not be further disclosed without the written authorization of the person to whom it pertains or otherwise permitted by 42 CFR, Part B.
- I may receive a copy.

Section F: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the individual listed in Section A. This authorization will expire in one year.

Signature of Individual/Individual's Personal Representative: _____ Date: _____

Section G: If Section F is signed by a Personal Representative, please complete the information below:

Personal Representative's Name: _____
Relationship to Individual: _____
Personal Representative's Address _____
City: _____ State: _____ Zip: _____ Country: _____
Personal Representative's Area Code & Telephone Number: _____

Date Sent: _____ Initials: _____
Faxed to: _____ Picked up by pt: _____ Mailed to: _____