AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

This Authorization is intended to comply with the HIPAA Privacy Rule for the release, use and disclosure of medical information, and if applicable, the release, use and disclosure of medical information with respect to minors, incapacitated patients, and deceased persons. The undersigned acknowledges that Galen cannot guarantee information disclosed pursuant to this Authorization may not be re-disclosed by the recipient and/or no longer protected by privacy regulations:

The undersigned, _____
[print name of person signing below]

[and designate one power by which the undersigned authorizes this release]:

☐ for Himself/Herself ☐ as Legal Guardian ☐ as Authorized Personal Representative

☐ as Custodial Parent ☐ with Health Care Power of Attorney ☐ as Executor of Patient's Estate

☐ as Spouse of Deceased Patient
[only if no other known authority listed above]

hereby authorizes Galen Medical Group, P.C. ("Galen") to disclose the medical record for:

_____, born _____
[*print name of patient*] [*date of birth*]

To:_____ [*party to whom records will be released*]	From:_____ [*party releasing records*]
Address:_____ _____	Address:_____ _____
Phone: _____ [*required only for fax or secure email verification*] Fax:_____	Phone:_____ Fax:_____
E-mail: _____ [only *for verification and encrypted records*]	E-mail:_____

GALEN

GALEN MEDICAL GROUP, P.C.

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Dates of Service:_____

Information to be Released

- □ Entire Medical Record (clinical and billing)
- □ Clinical Record
- □ Billing Record
- □ History & Physical
- □ Operative Report
- □ X-Ray
- □ Clinic Visits
- □ EKG
- □ Discharge Summary
- □ ER Records
- □ Laboratory
- □ Physician Orders
- □ Other:_____

Purpose of Release

- □ Attorney
- □ Social Security
- □ Continuation of Care
- □ Worker's Compensation
- □ Request of above named individual
- □ Disability
- □ Insurance
- □ Disposition
- □ Billing
- □ Other

by the following means [choose one]:

☐ mail ☐ fax ☐ E-Mail

☐ pick up in person ☐ USB

GALEN HAS NOT DETERMINED WHETHER OR NOT INFORMATION CONCERNING THE DIAGNOSIS OR TREATMENT OF SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV OR AIDS, MENTAL HEALTH, AND/OR THE USE OF ALCOHOL, DRUGS, OR TOBACCO MAY BE PRESENT IN THIS MEDICAL RECORD. IF SUCH INFORMATION MAY BE PRESENT IN THE MEDICAL RECORD, THE UNDERSIGNED AUTHORIZES THE RELEASE OF SUCH INFORMATION.

☐

Initials Required for this Authorization to be effective for any portion of the Medical Record

The undersigned acknowledges that any prior agreements to restrict protected health information ("PHI") do not apply to this authorization and that Galen is hereby authorized to release and disclose the information identified above without restriction, except as set forth in this authorization.

The undersigned further understands that:

- -This authorization is voluntary and the undersigned is not required to sign this authorization.
- -This authorization is effective for one year, but may be revoked in writing at any time, except for any actions Galen may have already taken in reliance on this authorization prior to the time of the revocation.
- -This authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof not prior to the expiration date.
- -If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy rules and may be shared with others.
- -Upon request, I may receive a copy of this authorization form after I sign it.
- -A photocopy or facsimile of this authorization shall be valid and effective, just as the original.
- -Galen will not receive financial or in-kind compensation or remuneration in exchange for the disclosure of the patients protected health information unless an applicable legal exception applies.

_____ _____

signature of patient or patient representative pursuant to the designated authority above [date signed]

accepted and verified by _____ on _____

[Galen Representative] [*date*]

I understand and agree that Galen is relying on my status as the personal representative of the patient. Under penalties of perjury, I hereby certify that to the best of my information and belief I am a personal representative.