PRIMARY
MED CLINIC

HIPAA Authorization for Release of Medical Information

PATIENT INFORMATION

First Name:_____ Middle Name:_____ Last Name:_____
Date of Birth: ____ / ____ / _____
Address: _____
City: _____ State:_____ Zip:_____
Home Phone: _____
Mobile Phone:_____
Email Address:_____

AUTHORIZATION

I hereby authorize Primary Med Clinic, LLC., its employees, agents and representatives to:
☐ Release Information to: _____
☐ Obtain Information from:_____
Name/Organization: _____
Address: _____
City: _____ State:_____ Zip:_____
Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED

☐ Complete Medical Record
☐ Office Visit Notes
☐ Laboratory Results and/or Diagnostic Tests
☐ Imaging Reports
☐ Immunization Records
☐ Medication / Prescription History
☐ Billing / Insurance Information
☐ Other (specify): _____

SENSITIVE INFORMATION (Requires Additional Consent)

I understand that federal and state law requires specific and separate authorization for the release of certain highly sensitive records. By initialing below, I expressly consent to the release of:
_____ HIV/AIDS test results, diagnosis, or treatment information
_____ Mental health records (including psychotherapy notes, counseling, psychiatric treatment)
_____ Alcohol or drug abuse treatment records

PURPOSE OF DISCLOSURE

☐ Continuity of Care and Coordination of Care
☐ Insurance, Payment, or Reimbursement

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☐ Legal, Administrative, or Compliance Purposes
☐ Personal Use
☐ Other: _____

EXPIRATION

This authorization will expire:
☐ On this date: ____ / ____ / _____
☐ One year from the date of signature
☐ Other: _____

PATIENT RIGHTS

I understand this authorization is voluntary and refusal to sign will not affect my right to receive medical care or treatment at Primary Med Clinic, LLC. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization. I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). I understand that psychotherapy notes, substance abuse treatment records, and HIV-related information are afforded additional protections under federal and state law and disclosure of these records without my initials above is strictly prohibited. I acknowledge that I am entitled to receive a copy of this signed authorization form.

SIGNATURE

Patient/Authorized Representative Signature: _____
Printed Name: _____
Date: ____ / ____ / _____

If signed by an authorized representative:
☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____
Witness (if required): _____ Date: ____ / ____ / _____

Request for Release of Health Information can be submitted to:
Primary Med Clinic, LLC
3605 W. Cortarto Farms Road Ste. 157
Tucson, AZ 85742
Phone: (520) 333-5902
Fax: (520) 666-3233

DISCLAIMER: *Refusing to authorize the release of sensitive records (HIV, mental health, or substance abuse treatment) will not affect a patient's right to receive general medical care, treatment, or benefits from Primary Med Clinic, LLC.*