Midha Medical Clinic
Raju Midha, M.D.

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name ______________________ **Patient's Date of Birth** ______________________

Address ______________________ **Patient's Telephone Number** ______________________

City, State Zip Code ______________________ **Any Other Names Used** ______________________

I hereby request that Midha Medical Clinic use / disclose my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all):
____
2. Be sent to the following person / entity at the address listed:
____
Name
____
Address
____
City, State Zip Code
3. I authorize disclosure of the following specific information (include dates of service):
____
____
____

NOTE: UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: ☐ YES, PLEASE DISCLOSE THIS INFORMATION: ______________________

4. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **Unless otherwise specified below, I understand that my PHI will be provided in paper format**. I hereby request that my PHI be provided in the following format:
☐ on an encrypted USB drive ☐ on an unencrypted USB drive ☐ other (please specify) ______________________
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and would then no longer be protected by federal privacy regulations.
6. I understand I may revoke this authorization by notifying Midha Medical Clinic in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) ______________________.
8. This authorization expires on __________ ____, 20____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please specify) ______________________.

FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If the charges will exceed $25, we will inform you of the approximate charges <u>prior</u> to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

______________________	______________________	______________________
Signature of Patient	**Date of Patient's Signature**	**Patient's Date of Birth**
______________________	______________________	______________________
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	**Date of Legal Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

For Midha Medical use only

Date Received	Date Processed	Format	Fee	Pt Notified of Fee	Medical Record #