ZAND MEDICAL PARTNERS
AUTHORIZATION OF USE OR DISCLOSURE OF HEALTH INFORMATION

Name of Patient: ________________________ Birthdate: ___________

Contact Phone Number: ______________________

The person named above authorizes the following information to be requested or released by representatives of Zand Medical Partners

I hereby authorize

____
Name of Person or Facility

____
Address

____
City

_____________________________ _____________________________
Phone Fax

- ○ Send health records to:
  and/or
- ○ Discuss information with:

____
Name of Person or Facility to receive information

____
Address

____
City

_____________________________ _____________________________
Phone Fax

SPECIFY RECORDS

Check the box and initial to specify which type of information is to be released

- ○ All health information pertaining to my medical history, physical condition and treatment ____(initial); **OR**
- ○ Only the following records or type of information (specify and include dates)

____/_____ (initial)

- ○ I specifically authorize release of the follow information (initial as appropriate):

_________ Mental health treatment information
_________ HIV test results
_________ Alcohol/drug treatment information

- The recipient may use the health information authorized on this form for the following purpose:
    - Coordination of Care
    - Other: ___________________________________

DURATION
This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____/_____/_____ (Date)

TO CANCEL THIS AUTHORIZATION
You or your representative can cancel this authorization upon written request. If you cancel this authorization, it will not affect information disclosed before the receipt of written request.

MY RIGHTS

You have the right to inspect the information you are authorizing to be released. This and other specific rights regarding the handling of your health information is outlined in the Zand Medical Partners Notice of Privacy Practices.
The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. Zand Medical Partners is not responsible for the actions of others who may be provided with information released as a result of this authorization
You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to this authorization will not affect your eligibility for benefits.
You have the right to receive a copy of this authorization.

SIGNATURE

Print Name:
____

Signature:
____

If signed by other than patient, indicate relationship: _____________________________

FEE
There may be a fee associated with the copying of your records

Mailed______ Faxed: _________ Picked up by patient: _______