AUTHORIZATION TO DISCLOSE CLINICAL/FINANCIAL INFORMATION

Patient Name:_____ Date of Birth:_____
Address:_____ Phone number:_____
City/State/Zip_____

The privacy of the patient's protected health information is very important to Unity Medical Center and Grafton Family Clinic. The patient has the authority to control access to and disclosure of protected health information except for those disclosures that are allowed without patient authorization (as listed in the Notice of Privacy Practices). This form does not authorize the release of my official medical records; those will need to be requested using the Release of Information Form. This form does not give proxy access, that will need to be requested using the Proxy Request Form or completed via MyChart.

In filling out this form, I hereby request that:

- ❑ Clinical information (i.e., test results, scheduled appointment information, clinical findings, and care decisions) only.
- ❑ Financial/billing information only.
- ❑ Both clinical and financial information.

Can be discussed or shared with the following person(s)/facility:

Name	**Relationship**	**Telephone number**

This authorization to disclose information to the designated individuals also includes the indicated sensitive records.

(Please initial)

Psychotherapy Notes: _____

HIV or AIDS: _____

Chemical Dependency: _____

- ❑ My authorization is not limited to a certain time period or visit date.
- ❑ Limited authorization for the following time period or visit date(s): _____

I understand that this authorization will remain in effect until such time that I revoke it in writing to Unity Medical Center Health Information Management Department.

Patient/Patient Representative Signature: _____

Date: _____