SQUARE MEDICAL

AUTHORIZATION FOR RELEASE OF PROTECTED HEATHCARE INFORMATION

Printed Name of Patient: _____DOB: _____Pt. #_____

I hereby authorize the release of information (check one or both) ☐ from Square Medical Group to:
☐ to Square Medical Group from:

_____
(Name of facility or person) (Phone) (Fax)

_____
(Street) (City) (State) (Zip)

Please release the following information selected from the below list.
I understand that information can be released by the following means: verbal, telephone, written, faxed and/or email communications.

☐ Treatment Summary/Discharge
☐ Treatment Plan/Progress
☐ Release for Substance Use Treatment
☐ HIV Information
☐ Other (specify) _____

☐ Transfer of Care
☐ Coordination of Care
☐ Release for Mental Health Treatment

_____

I understand that:

I am authorizing the Use or Disclosure of Protected Health Information. This form is protected by the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R Parts 160 and 164.
I may withdraw my authorization at any time by submitting a written request to Square Medical Group. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization. If the authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy, even if authorization has been withdrawn. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected. Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Square Medical Group.

Message to the Recipient regarding Alcohol and Drug Abuse Treatment: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of the medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 CFR, 2.32)

Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do not sign a blank authorization form.

_____
Signature of Patient Date Signed *

*Unless I specify an expiration date (_____) , this release will expire 1 year from the Date Signed.

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