Authorization/Release of Protected Health Information (PHI)

Patient Name: ____ DOB: ____________________

Address: ____

City/State/Zip: ____

I hereby authorize HealthMark to disclose Protected Health Information of the patient listed above to:

Name/Organization: ____

Address: ____

Phone: _____________________________________ Fax: _____________________________________

Reason to release Protected Health Information: _____________________________________

Please note: If this information is not being released to another physician's office there may be a fee involved. Please call (800) 367-1500 or visit cioxhealth.com for more information.

Please disclose the following healthcare information (check all that apply)

____ All my health records generated **only** by HealthMark Physicians/Providers

____ All my health records from HealthMark **and** maintained records from other facilities

____Only records related to: ____

____ Specific Date Range: From: __________________ To: ____________________

(Circle Include or Exclude)

Include or Exclude: My health information related to drug/alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by filling out a revocation form available from the office or by writing a letter to this office. This authorization will remain in effect for one year from the signing date. Once HealthMark discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient/Parent/Legal Guardian: ____

Date: __________________________