MOSAIC
FAMILY HEALTH

Authorization for Release of Medical Information

Photocopy or facsimile of the original authorization will be considered as valid as the original

Patient Information

Name – Last, First, MI			Date of Birth
Street Address			Medical Record # (if known)
City	State	Zip	

Release From:

Organization/Person Name:		
Street Address or Fax #		
City	State	Zip Code

Exchange With/to: (only one person/organization per authorization)

Organization/Person Name:		
Street Address or Fax #		
City	State	Zip Code

Information to be Disclosed: ☐ Verbal ☐ Written

☐ All Records ☐ Radiology Reports ☐ Pathology Reports ☐ Immunization
☐ Clinical Office Notes ☐ Laboratory Reports ☐ History/Physical ☐ Other: _____

For the Following Dates: From: _____ To: _____

Disclosure Requiring Special Consent: In compliance with state and federal laws, which provide additional protections to certain types of information, I am specifically authorizing the disclosure of records related to HIV/AIDS test results, mental/behavioral health, developmental disabilities, and drug and alcohol abuse or treatment, unless I limit the disclosure to exclude the following: _____

Purpose for Disclosure:

☐ Consultation / Referral ☐ Work Comp ☐ Changing Providers ☐ Legal Matter
☐ Personal Use ☐ Insurance / Claim ☐ Disability Determination ☐ Continuity of Care
☐ Other: _____

Your Rights with Respect to this Authorization

I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. I understand that I have the **right to receive a copy of this authorization.** I understand that if I agree to sign this authorization, I will be provided a copy of it. I have the **right to refuse to sign this authorization** and that the person(s) and/or organization(s) listed above who I am authorizing to use and /or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **I understand that I have the right to withdraw this authorization**-written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or receive a copy of my withdrawal, I may contact the health information department. I am aware that my withdrawal will not be effective to use and /or disclose of my health information that the persons(s) or organization(s) listed above have already made in reference to this authorization.

Re-disclosure notice: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal Privacy Standards

EXPIRATION DATE: This authorization is good until the following date(s)_____or for one (1) year from the date signed.

I have had the opportunity to review and understand the content of this authorization from. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Legal Rep: _____ Date: _____

Relationship: _____ AUTHORITY TO SIGN REASON: _____