**Dover Family Physicians, P.A.**

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth___/___/___/ Address: _____ City: _____
State: _____ Zip: _____ Email address: _____ Phone: _____ Social Security **xxx-xx**-_____

**I request that my protected health information from**: _____ be disclosed to:

Recipient Name: _____ _____ Address: _____
City: _____State:_____ Zip: _____ Email address: _____ Phone:
_____ Fax (healthcare provider only): _____

**I authorize the following protected health information to be released from my medical record (s):**

____ Discharge Summary _____ Consultation Reports Dates ____ History and Physical

____Test Results Date: _____ Type: _____ ____EKG Report Date _____Emergency Report Date: ____

____Radiology Report Date ____Laboratory Report Date ____Operative Report

Detailed Description: _____
Other: _____

I understand that the information in my health record mat include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

**State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/ obtained:** (Include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records: ___ yes ____no Dates: _____
HIV Testing and Results: ___yes ____no Dates: _____
Mental Health and Psychotherapy Reports ___ yes ___ no Dates: _____
**Covering the period of health care from:____ Specific Dates:_____ to _____** OR
**____- All past encounters past, present and future encounters/visits.**

**Purpose for requesting information:** ____ Legal ___ Insurance _____Personal ___ Continuing/Transfer Care

**Disclosure Format (Paper is default not marked):** ___ US Mail- paper format, ____ Fax (Healthcare Providers Only) ____ CD-secure electronic format

**By signing this authorization form, I understand that:**

- Request or copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time Revocation must be made in writing and presented or mailed to the Health Information Management at the following address: 1342 S. Governors Ave. Dover DE 19904. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, **this authorization will expire on the following date: _____ (If fail to specify an expiration date this authorization will expire in one year from the date signed.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**I certify** that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____ ___/____/_____/ _____
(Signature of Patient) (date) (relationship to patient)

_____ ___/_____/____/
(Signature of Witness) (date)