PROTECTED HEALTH INFORMATION REQUEST FORM

THIS FORM IS TO BE USED WHEN PATIENTS WISH TO REQUEST MEDICAL INFORMATION TO BE SENT TO ALCONA HEALTH CENTERS FROM ANOTHER SOURCE

A photocopy or fax of this authorization is as valid as the original. If I give VERBAL consent for obtaining my medical information a copy of this form, completed by Alcona Health Centers staff on my behalf, will be mailed to the address below.

PATIENT'S FULL NAME: DOB:

STREET ADDRESS:

TELEPHONE NUMBER:

I hereby authorize Alcona Health Centers to request my confidential health information from:

From:
Street, PO Box
City, State Zip:

Information to be obtained- see attached protocol list.

( ) OTHER – Specify

My PCP has changed to Please send all future office visit notes to this provider.

SPECIFY DATE RANGE OF RECORDS REQUESTED: to

Unless otherwise indicated, this authorization is valid for a 90 day period from the date it is signed. If other than 90 days, enter date:

Signature of patient, parent or personal representative Date

NOTE: ***If signed by someone other than the patient, we need written proof of your authority.***

Signature of Witness Date

PLEASE SEND ALL RECORDS REQUESTED TO THE FOLLOWING ADDRESS:

Information Received On: Received By:

Further uses and Disclosures: When we use or disclose your health information to other parties as you have instructed on this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws revocation

REVOCATION: You have the right to revoke this authorization at any time. When we receive your revocation in writing, we will immediately stop using or disclosing the health information you authorized us to use on this authorization form. Your revocation shall not apply to those uses or disclosures made on your behalf prior to the time we receive your written revocation.