Kettering Cardiothoracic and Vascular Surgeons, Inc.
HIPAA COMPLIANCE POLICY
Medical Records Release ("Authorization") Form

Patient Name:_____ Medical Record #.:_____

Date of Birth: _____ Social Security #: _____

Address: _____ Telephone #: _____

_____

I hereby authorize Kettering Cardiothoracic and Vascular Surgeons, Inc. to release my (my ward's) Medical Information to:

Name: _____ **Phone #:** _____

Address: _____

_____

Purpose of disclosure: _____
Dates of Service: _____

Type(s) of Medical Information to be disclosed (Please specify):

_____

_____

_____

This Authorization also specifically includes the release of records relating to the following ("X" appropriate boxes, if any):

☐ Diagnosis and/or treatment for alcohol and/or drug abuse**
☐ AIDS/AIDS Related Complex diagnoses and/or treatment
☐ HIV test result
☐ Diagnosis and/or treatment relating to mental health

A general authorization for release of these types of information is NOT sufficient for this purpose.

I understand and acknowledge that this Authorization extends to all or part of the records designated above. I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my medical information can no longer be disclosed pursuant to this Authorization except to the extent that disclosures have already been made in reliance upon this Authorization.

This Authorization is valid for one (1) year following the date entered below, unless an earlier date or condition/event is specified here _____ or unless revoked by me in writing before the release of the above designated information.

_____ _____
Signature of Patient (or Patient Representative) Date

***If this Authorization is signed by a legal representative of the patient (for example, the parent or legal guardian) a description of such representative's authority to act for the patient must also be provided (check applicable box and/or explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.**

__ Parent
__ Guardian
__ Power of Attorney
__ Health Care Proxy or Surrogate
__ Administrator/Executor of Estate

**For records covered by 42 CFR Part 2: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules Prohibit you from making any further disclosure of this 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 release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.