EAST GRANBY FAMILY PRACTICE, L.L.C.

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AUTHORIZATION TO OBTAIN & USE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

This document authorizes East Granby Family Practice, L.L.C. to obtain and use your Protected Health Information (PHI).

Name of individual(s) and/or practice(s) from which EGFP can receive your PHI from:

Doctor's Name:_____**Phone#:(** **)** **-**_____

Doctor's City, State:_____**Fax#:(** **)** **-**_____

Doctor's Name:_____**Phone#:(** **)** **-**_____

Doctor's City, State:_____**Fax#:(** **)** **-**_____

Information authorized to be obtained:

- ☐ All medical information concerning this patient for all dates of service.
- ☐ Patient summary with most recent visit notes, physical, lab data, immunizations, problem list/past medical history.
- ☐ Medical information of this patient compiled between ___/___/___ to ___/___/___
- ☐ Other (specify):_____

Dates of Treatment, if known:_____

The information will be obtained, used, or disclosed for the **following purpose(s)** only:

- ☐ Other insurance ☐ Legal process ☐ At the request of the individual or individual's representative
- ☐ Assist in the grievance/appeal process ☐ Assessment/referral/supervisory referral
- ☐ Other (specify):_____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by sending written notice to the receiving and disclosing entities named above. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:_____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine eligibility for enrollment or benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____ _____

Description of Legal Representative Authority Expiration Date of Authorization

NOTICE OF RIGHTS: Information in you medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission, except in limited circumstances, including disclosure to persons who have had risk exposures, pursuant to an order of the court or the Department of Health, among health care providers for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified, unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

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