New Horizon Health Center

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Authorization to Request and/or Release Protected Health Information (PHI)

Patient's Name: ____ Date of Birth: _____________________

Maiden Name: _____________________________________ Phone #: _________________________________

I request and authorize (Name/Address) ____

to release my protected health information to:

◯ Me or ◯ Name of provider: ____

Address (City, State and Zip Code):

____

In the following manner: ◯ Copies by mail, ◯ Copies to be picked-up ◯ Electronic ◯ Other:_______________

For (reason for disclosure): ____

This request and authorization applies to:

_______ All health care information

_______ PHI regarding the following diagnosis, treatment, or date of treatment: _________________________

_______ Other (i.e., Research, etc.) ____

I know that my written consent is needed to release any protected health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health, or drug or alcohol abuse. If I have been tested, diagnosed, or treated for any of the above named conditions, you are authorized to release health care information relating to such diagnosis testing, or treatments. _________ Patient's Initials

My permission is only in force and effective until the following date or event:

◯ ____________________________________ (list expiration date or event), OR

◯ End of research study (use only if use or release is for research).

I know that I have the right to withdraw this authorization, in writing, at any time by sending such written notice to the NHHC Health Information Management Department or Compliance Office. I understand that I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I also know that information used or disclosed before this authorization may be subject to re-disclosure by the person who received the information and may no longer be protected by state or federal law.

____ _____________ ___________________________________

Signature of Patient or Legal Representative Date Witness (NHHC employee)

____ ____

Print Name of Patient or Legal Representative Relationship to Patient, if signed by anyone other than patient