SMG Authorization to Use and Disclose Protected Health Information

Practice/Location Name: _____ **Practice ID#:** _____

SECTION I: Patient Information

Patient Name (Print): _____ Include other previous names: _____
Date of Birth: _____ Phone: _____ Patient Address: _____
City/ State/ Zip: _____ Email: _____

SECTION II: *I Hereby Authorize Steward Medical Group To:*

Please select one: ☐ Release copies of the above-named patient to ☐ Obtain medical information from
Recipient Name (*Self or Name/ Facility):* _____
Address: _____ City/State/ Zip: _____
Phone #: _____ Fax #: _____ Email: _____

SECTION III: Purpose of Request

☐ **Personal** ☐ **Referral or 2nd opinion** ☐ **Legal** ☐ **Insurance** ☐ **Other** _____

☐ **Transfer** (*Transfer reason):* ☐ **Moved/Moving** ☐ **Insurance No Longer Accepted** ☐ **Other** _____

SECTION IV: Information to be Released

☐ **2 Year Abstract of my records for all of Steward Providers *OR* Check AND Complete Below**

☐ **Office Visits:** Dates From_____ to _____ Provider(s)/ Specialties _____

☐ **Other** *(please specify)* _____

****** Please DO NOT pre-pay. You will be invoiced for your selection by our Vendor ******

SECTION V: Fee Information

COPY FEE: *For Patient record requests - Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the two-year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the applicable US state statute governing fees for medical records will be applied.*

SECTION VI: Delivery Format

Please select ONE from below. If nothing is selected, electronic copies will be sent via Secure email on file

☐ Email _____ ☐ Fax _____ ☐ Paper (via USPS) □ CD (via USPS)

SECTION VII: Restricted Authorization to Release Protected Information

IMPORTANT: The following categories of information may be included in your medical record and **WILL NOT** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

**** Please do not skip any items as it could impact our ability to fulfill your request and cause delays. ****

Initials	Category *(of Information to be released)*	Initials	Category *(of Information to be released)*
	Alcohol and/or Substance Abuse Treatment ***		HIV/ AIDS Screening Test Results/ Treatment
	Child/Elder Abuse or Neglect & Abuse of Disabled Adult		Mental/ Behavior Health or Disability Services *
	Confidential Communications w/ a Social Worker		Rape/ Sexual Assault victim Counseling
	Domestic Violence Victim Counseling		Sexually Transmitted Disease (STD)
	Genetic Testing/ Test Results **		Other *(specify)*:

* This Authorization is not valid for use or disclosure of psychotherapy notes.
** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.
*** Only applicable records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here _____ Date Here _____

Signature of Patient or Parent/Legally Recognized Representative **Date**

Term: This Authorization will remain in effect until Steward Medical Group (SMG) fulfills this request.
Revocation: I understand that I may revoke this Authorization at any time by requesting it of Steward Medical Group in writing at the address listed below. The revocation will be effective immediately upon Steward Medical Group's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Steward Medical Group in reliance on this Authorization before it received my written notice of revocation.
Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, or quality of my treatment at Steward Medical Group
Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by SMG.
Access: I understand that in certain circumstances Steward Medical Group has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials

Please deliver your completed form to your provider's office in-person, by fax, or by mail. If you have any questions regarding your request, please contact your provider's office.

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