



Neighborhood Doctors Who Care

Patient's Name: _____ Date: _____

Date of Birth: _____ Insurance ID: _____

Address: _____ Telephone Number: _____

1. I authorize the following organization(s) / physician(s) to disclose the subsequent health information:

Name: _____

Address: _____

Phone: _____

2. Please release the subsequent information to the following organization(s) / physician(s):

Name: _____

Address: _____

Phone: _____

3. The health information that I am requesting is as follows: *(check all appropriate lines)*

- Progress Notes (please specify physician & time frame)
- Immunization Records
- Diagnostic Testing: (specify type of test(s) and date(s) below)
- Other: (please describe below in detail)

4. The information for which I am authorizing disclosure will be used for the following purpose(s):

- My personal needs
- Sharing with other health care providers
- Other: (please describe)

PLEASE FILL OUT OTHER SIDE OF AUTHORIZATION

5. I understand that the information being requested may include records relating to sexually transmitted diseases, Human Immunodeficiency Virus (H.I.V), Behavioral or Mental Health services, and treatment for alcohol or substance abuse. If you wish not to have any of the above mentioned information released, please initial here. _____
6. I understand that I have the right to revoke this authorization at any time. I must provide in writing my revocation to the Medical Records Department. I understand that this revocation will not apply to any information that had already been released due to this authorization.
7. This authorization will expire on _____.
Failure to put a date in this spot, this authorization will expire 6 months from the date on which it is signed.
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
9. Manhattan Physician Group may not condition treatment, payment, enrollment or eligibility for benefits based on an individual signing the authorization when the prohibition on conditioning authorization applies.
10. I understand that no health information can be provided to anyone other than the signer unless otherwise indicated.

Signature of Patient: _____ Date: _____

OR

Signature of Legal Representative / Relationship: _____ / _____ Date _____

____ Pick up at Site ____ Mail to address on front page

For staff purposes only:

Signature of Witness: _____ Date: _____

____ Proper identification was provided

Identification provided:

____ Driver's License

____ State issued photo ID

____ Health Care Power of Attorney

____ Health Care Proxy

____ Birth Certificate

____ Passport

The Manhattan Physician Group follows the guidelines established by HIPAA. A copy of this authorization form is to be provided to the patient when request is completed.