Authorization to Use and/or Disclose Medical Records

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Name of Patient: _____DOB: _____ SS# _____

Recipient of Records	***Who is releasing the records?***
Records To: Dunbar Medical Associates, PLLC	Records From:_____
Address: 3752 Teays Valley Road Hurricane, WV 25526	Address: _____
Phone: 304-757-3131 Fax: 304-768-4072	Phone: _____

For the following purposes:

□Continued Medical Care	□Personal Information	□Legal Follow-Up
□Disability Insurance	□Other	

By checking the boxes below, I specifically authorize the use and/or disclosure of the flowing health information and/or medical records, if such information and/or records exist:

□Please send the entire Medical Record (all information) for the above named recipient.

-------OR-------

□Office Notes & Reports	□Most Recent One Year History	□Most Recent 3 Year History
□Rx History	□Transcribed Hospital Reports	□Laboratory Reports
□Billing Statements	□Diagnostic Reports	□Diagnostic Films

□Others (listed here): _____

The following items must be initialed to be included in the use and/or disclosure:

— HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

— Mental health information and/or records

— Domestic Violence

— Genetic testing information and/or records

— Drug/alcohol diagnosis, treatment or referral information (federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____

I understand if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPPA and other federal and/or state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I further understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand I may revoke this authorization at any time, provided I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in six (6) months from the date of signing or until (insert date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patients or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to Patient: _____