

# Completing an Authorization to Disclose Protected Health Information Form

**Authorization to Disclose Protected Health Information**  
This form is for all record requests.

<p><b>RELEASE INFORMATION FROM:</b>  <small>Specify Provider/Organization Name and Facility Address</small></p> <p>Organization Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>	<p><b>RELEASE INFORMATION TO:</b>  <small>Specify Provider/Organization Name and Facility Address</small></p> <p>Organization Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>
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By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

**IDENTIFYING INFORMATION AT THE TIME OF SERVICE**

PATIENT'S FULL NAME \_\_\_\_\_

MAIDEN OR OTHER NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ SSN/PATIENT ID # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
Mailing Address, City, State, Zip

\_\_\_\_\_

Covering the period(s) of health care:

FROM (Date) \_\_\_/\_\_\_/\_\_\_ TO (Date) \_\_\_/\_\_\_/\_\_\_

1. Information authorized for disclosure, if included in my records:

Laboratory test results

Other (please specify) \_\_\_\_\_

2. If applicable, I also give permission for the following "Sensitive Protected Health Information" to be disclosed (please initial below):

Other (please specify) \_\_\_\_\_

initial \_\_\_\_\_ I understand that the information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

Sanesco International 1010 Merrimon Ave, Asheville, NC 28804 (866)670.5705 info@sanescohealthc.com

This should be Sanesco's information:  
 Sanesco International  
 2 Trident Dr.  
 Arden, NC 28704

Please see Further Instructions, below

Please indicate your name, identifying information and address.

"From" date should be the date you collected your first sample. "To" date should be at least 30 days later.

Please check "Laboratory Test Results."

Optional; however, if you check the box next to "Other," please specify what information to release and initial the line next to the bottom paragraph.

## Further Instructions, "Release Information To" box

Please fill in this box as follows.

- If you wish for us to send your information to you, please use your name for the Organization Name and indicate your address
- If you wish for us to send your information to another person, such as a family member, a new healthcare practitioner, an attorney, etc., please list that individual's name as the Organization Name and include his or her address
- If you wish for us to send your information to a clinic, court, law firm, school or other organization not affiliated with the practitioner who ordered your test, please list their name as the organization name and provide their address.
- Note that this form must be notarized if we are to release information to an attorney, a law firm and/or a court. Please see second page.

Please see next page.

3. The purpose for which disclosure is authorized (check where applicable):  
 Medical Care    Insurance    Benefit eligibility  
 Other: \_\_\_\_\_

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:  
 (Date) \_\_\_/\_\_\_/\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here \_\_\_\_\_) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

5. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: Patient – (or Legal Representative, Parent or Legal Guardian)      (Relationship if not Patient)  
 ID Provided \_\_\_\_\_      Date \_\_\_/\_\_\_/\_\_\_\_

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or court.

Official Use Only  
 Name/Title of Person Releasing Information: \_\_\_\_\_  
 Date \_\_\_/\_\_\_/\_\_\_\_

This section is optional.

See Further Instructions, Section 4, below

This paragraph is purely informational and does not require any action

Please sign here

See Further Instructions, Section 6, below

For office use only: please leave blank

#### Further Instructions, Section 4

The first paragraph is to inform you that you have the right to revoke this authorization at any time by giving us written notice. You do not have to state a reason.

The final sentence of this paragraph states that you may set a date, event or condition for this authorization to expire. Events and/or conditions may be anything you want. Clearly write the desired event or condition in the space immediately after the final colon in this paragraph. If you do not wish to specify an event or condition, simply leave this space blank.

The second paragraph begins with a space for you to indicate a date upon which this authorization will expire. If you do not wish to specify a date, simply leave this blank.

Near the middle of this paragraph is a space for you to initial if you wish to make this authorization permanent. If you choose to make this authorization permanent, you will still have the right to revoke it at any time by giving us written notice.

#### Further Instructions, Section 6

Notarization is required if we are releasing your information to an attorney, a law firm and/or a court. The Notary Public must complete the following:

- *ID Provided:* The number associated with the identification (ID) used to prove your identity to the Notary Public. Examples of acceptable ID may include a state-issued driver’s license or ID card, a U.S. Military ID card, a U.S. Passport, etc.
- *Date:* The date on which notarization occurred
- *Witness or Notary:* The notary’s signature and seal

If we are not to release the information to an attorney, law firm and/or a court then notarization is not required and these three fields may be left blank.