Open Hands DPC

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
Open Hands Direct Primary Care, PLLC.

Patient Name: _____ Date of Birth: _____ Phone: _____

Address: _____

With my signature below, I authorize:

Facility/Provider: (list name, address, fax number)

_____ _____

_____ _____

to DISCLOSE Information via fax or email to:

Open Hands Direct Primary Care, PLLC

Fax: 859-545-5016 Email: DrKelli@openhandsdpc.com

Information to be used/disclosed consists of medical and/or mental healthcare information, including:

___Notes with Assessment or Evaluation and Treatment Plan (past 3 years)

___Labs/Imaging Results ___Medications ___Other: _____

The purpose of the disclosure/ communication is for Coordination of Care.

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information WILL BE DISCLOSED if I place my initials in the applicable space below:

Initial: _____ Mental health information

Initial: _____ Genetic Testing information

Initial: _____ Drug/alcohol diagnosis, treatment, or referral information

Initial: _____ HIV / AIDS information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from receiving primary care or mental health treatment at Open Hands Direct Primary Care, PLLC. Although it may limit the extent to which specific treatments (i.e. medications) can be pursued. I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here.

Permission for release of records:

_____ _____

Patient Name Date

_____ _____

Patient/Guardian Signature Relationship to Patient