MANHAN INTERNAL MEDICINE
Authorization for Release of Information

Patient Name: ________________________________ D.O.B. _____________________

Address: ______________________________________ Phone#: ___________________

Please Check one _______ Pick up ______ Mail

☐ **OBTAIN**

I hereby authorize ____To disclose my Protected health information to: **MANHAN INTERNAL MEDICINE**
2 Mechanic St, Suite A
Easthampton, MA 01027

☐ **DISCLOSE**

I hereby authorize **MANHAN INTERNAL MEDICINE** to disclose my protected

Information to: ____

Address:____

1. This release is authorized for the following purpose (s)

[ ] Continuation of care. [ ] Legal [ ] Transfer
[ ] other ____

2. The information to be disclosed included:

[ ] Entire Record [ ] Lab results [ ] Diagnostic tests [ ] Office Notes
[ ] Other: ____

3. Authorization Covers:

[ ] Entire period of care [ ] Past ________ Years [ ] Specific dates ___________________________

4. Authorization covers the release of sensitive, protected information onlt if indicated by **YOUR** initials and signature below:

________ HIV/AIDS ________ Mental Health/Psychiatry
________ Sexually Transmitted Diseases _________ Drug/Alcohol Dependence

____ _______________________
Signature of Patient or Authorized representative. Date

This Authorization expired on: _____________ (or if unspecified, 180 days from the date of signature.)

I understand that I have the right to revoke this authorization in writing by notifying the medical provider named above. I understand that actions taken in reliance of this authorization prior to revocations may not be reversible.

I understand the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal privacy regulations.

I understand that I may refuse to sign this authorization.

____ ____________________
Signature of patient or authorized representative Date