Royal Oak Medical Associates, P.C.

Family Physicians of Marion

Robert Van Clampitt, MD
Kim Ellison, FNP
Brian H. Stiefel, MD
Dayle Zanzinger, FNP
Meghan Mullins, PA

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as describes:

Patient name:_____ Date of Birth: _____

Address: _____ SSN: _____

_____Phone #: _____

The following physician and/or organization is authorized to make the disclosure:

_____

treatment dates: _____

The information may be disclosed to and used by the following individual or organization:

_____

Check the following information to be disclosed:

- ❑ Consultation Reports
- ❑ Discharge Summaries
- ❑ Laboratory Results
- ❑ Complete Health Record , History and Physical
- ❑ X-ray reports
- ❑ Progress notes
- ❑ Other _____

Sensitive information: I understand that the information in my record my include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that my disclosure of information carries with it the potential for re-disclosure and that the information may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study be denied I understand that I may inspect or obtain a copy of the information that is to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition (if I do not specify an expiration date this authorization will expire in six months):

_____ _____

Signature Date

_____

If signed by legal representative, relationship to patient

Notice: Records obtained from Family Physicians of Marion have an average turn-around time of fifteen days. There may be a charge for records released