Al-Afiyah Medical Care

"We care. God Cures."

Authorization for Use and Disclosure of Protected Health Record Information

From Physician Name: _____ Fax: _____

The information that is to be released from my medical records is for the following purpose:

Is authorized to release the following:

☐ Discharge Summary	☐ History and Physical	☐ Operative Reports	☐ Pathology Reports
☐ Laboratory Reports	☐ Consultation Reports	☐ EKG/ECHO	☐ Emergency Room Records
☐ Shot Records	☐ Progress Notes	☐ X-Ray Reports/Films	☐ Occupational Health
☐ Senior Health Records	☐ Basics/Abstracts	☐ Psychiatric Records	☐ Continued Medical Care
☐ Complete Records	☐ Itemized Bill	☐ Billing / Claims	☐ Other:

To : Afiyah Medical Care

Phone: 718-360-4843 Fax: 718-360-4810

Releasing information about drug abuse, alcohol abuse, psychiatric care, and SIDS

I understand if my medical or billing records contain information that reference my drug abuse, alcohol abuse, psychiatric care, sexually transmitted disease history, Hepatitis B or C testing, and/or other sensitive information, I still agree to its release.

Please check one: _____Yes _____No _____Initials

I understand if my medial or billing record contains information that refers to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I still agree to its release.

Please check one: yes_____ No _____ initials Time limit and right to revoke authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Doctors of Afiyah Medical Care.

Re-disclosure

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA-Act of 1996). Afiyah Medical Care employees are hereby released from any form of legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Management of medical records

I understand that once Afiyah Medical Care have received and reviewed these medical records, the necessary records will be scanned into the patient's chart and the remaining medical records will be properly disposed of per HIPAA standards.

Signature of patient or personal representative

I authorize **Al Afiyah Medical Care,** to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for copies.

_____

_____ _____

Print Name Date of Birth

_____ _____

Signature Date