KACHINA
FAMILY PRACTICE

Authorization for Kachina Family Practice to Disclose My Health Information

Patient name: _____ Date of Birth: _____

Previous Name: _____

I. My Authorization

You may disclose the following healthcare information (check all that apply):

☐ All my health information including, but not limited to, AIDS/HIV and Other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted:

_____

☐ My health information relating to the following treatment of condition: _____

☐ My health information for the date(s): _____

☐ All Psychotherapy notes unless specifically excepted: _____

☐ Other: _____

You may disclose this health information to:

Name (or title) and Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply): ☐ at my request: _____

☐ other (specify): _____

This authorization ends: ☐ on (date) _____

☐ when the following event occurs: _____

II. My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party.
I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or to write a letter to the office.
Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.
I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Print Name if signed on behalf of the patient Relationship to patient