AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this is to request copies of the following protected health information from IHP Medical Group

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Contact No: _____

1. I hereby authorize the following person(s)/Entity: INTERNATIONAL HEALTH PROVIDERS ***Name of Entity/Individual/Class of Persons*** 655 HARMON LOOP ROAD, SUITE 108 ***Address*** DEDEDO, GUAM 96929 ***City/State/Zip Code*** (671) 633-4447 (671) 633-4452 ***Phone*** ***Fax***	**To release to:** _____ ***Name of Entity/Individual/Class of Persons*** _____ ***Address*** _____ ***City/State/Zip Code*** _____ _____ ***Phone*** ***Fax***

2. I authorize the following types of information to be released:

□ HIV/AIDS □ Substance Abuse □ Behavioral Health Notes

□ Clinic Notes (includes face sheet, discharge summary, History & Physical, Operative Reports, Pathology and Consultation notes)

□ Pathology □ Cardiology Reports □ Hospital Discharge Summary

□ Consultations □ Radiology Reports □ History & Physical □ Labs □ Radiology Films _____

□ Operative Report □ ER Record □ Other (please specify below) _____

3. This information is needed for the following purposes:

□ Continued Care □ Insurance Claim □ Personal Use □ Legal Purposes

□ Other: _____

4. I understand that i have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Facility medical Records Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, even or condition: _____

_____

If I fail to specify an expiration date, event, or condition, the authorization will expire in **12 months**

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected Federal or State Privacy Laws. If I have questions about disclosure of my protected health information, I can contact the IHP Privacy Officer at (671) 633-4447. I also understand that obtaining medical information under false pretense is a Federal and State crime, punishable by up to 10 years in prison.

6. If present, alcohol and drug abuse information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations 42CFR, Part 2, prohibit making any further disclosure of records with out the specific written authorization of the person to whom it pertains or as otherwise permitted by law.

Signature of Patient or Legal Representative	Date
If Legal Representative, Relationship to Patient	Signature of Witness