AmIOK AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I. I hereby authorize AmIOk to disclose the following information from the health records of:

Patient Name (Print): _____
Date of Birth: _____ AmIOK Record Number: _____

II. Information to be disclosed:

[ ] Complete Health Record
[ ] History and Physical Examination (assessment, recommendations, treatment summary, medication(s)
[ ] Consultation Reports
[ ] Laboratory Tests
[ ] Counseling and therapeutic services
[ ] Discharge Summary
[ ] Other (Please Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse. _____(Initials)

III. This information is to be disclosed to:

Person(s) to Receive Information:
Name/organization: _____
Relationship:_____
Address:_____
Phone:_____
Fax: _____

For the Purpose (s):
_____

IV. 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 in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact AmIOK program staff. (Initial)_____

V. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to AmIOK. I understand that the 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 the insurer with the right to contest a claim under my policy.

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Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____, **or ONE YEAR from the date of signature.**

The AmIOK program staff and TCNJ are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. (Initial)_____

VI. I understand that after signing I will be given a copy of this authorization form, if requested. (Initial)_____

Signature of Patient or Legal Representative (Parent/Guardian of child under 18 years of age)

X:_____

DATE:_____

If signed by legal representative, relationship to patient:

X:_____

Signature of Witness:

X:_____

Date: _____