AmberMed

PHONE: 785.675.3018
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HIPAA INFORMATION RELEASE

PATIENT NAME_____ DATE OF BIRTH_____

May Hoxie Medical Clinic and/or members of the office staff release patient health information to a specified person other than the patient such as a spouse or parent/legal guardian? ____Yes ____No

If yes, please specify to whom this information may be released:

Authorized Person	Relationship to you	Date of Service	Bills	Lab Results	X-ray Reports	Meds	Medical Records Provider Notes

I understand that as part of my continuing healthcare, AmberMed maintains medical records, which contain my health history, symptoms, examination, test results, diagnoses and treatment plans. These are to be used as a basis for planning my care and treatment, and this information may be released to my other healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that this document is a part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

I understand that this clinic keeps on premises a copy of the "Notice of Privacy Practices" which provides a more complete description of the uses and disclosures of my medical record.

I hereby acknowledge that I have been provided a copy of this document or the opportunity to review this document prior to signing below.

_____ _____

Patient or Legal Representative
(with authority to make healthcare decisions)

Date