Scott L. Sledge, M.D. PA

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the Practice of: _____M.D. or any of its employees, staff or agents, to use and disclose health information from the medical record(s) of:

PATIENT NAME:_____

ADDRESS:_____
(Street) (City) (State) (Zip Code)

DATE OF BIRTH:_____ MEDICAL RECORDS #:_____

HIV/AIDS : I consent to the release of any positive or negative test result fro AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical record.
Initial:_____ **Date:**_____

Limitations on the information you may release subject to the Release Form are as follows:
Date(s) of Treatment: From_____ **To**_____

The reason(s) or purpose I permit this confidential information to be released for the following:

_____ **Continuing Medical Treatment** _____ **Litigation for Review**

_____ **Insurance: Insurance Company Name:**_____

_____ **Other: Specify Reason:** _____

Release Information to:_____
(Name of individual or organization)

_____
(Street) (City, State, Zip)

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a 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 individual or organization releasing information. I understand that the revocation will not apply to information already 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 expires upon completion of this request or upon the following date:_____.

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sigh this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 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 by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer for this institution at 210-.

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This consent permits the practice to use and disclose my health information to carry out treatment, payment or health care operations. Additional information regarding the uses and disclosures of health information is described in the practice's "notice of privacy practices." A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions uses and disclosures of health information for treatment, payment, and health care operations purposes. However, the practice is not required to agree to a patient's request for restrictions. This consent to release confidential information may be revoked by me in writing, at any time, except to the extent that action has already been taken. No further confidential information will be released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS AND AGREE NOT TO SUE the Practice, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

_____(Print Patient's Name)

_____(Signature of Patient) Date:_____

_____(Signature of Legally Authorized Person)

_____(Physician Signature)