SCFM CONVENIENCE CLINIC PLLC

160 Warrior Drive, Stephens City, VA 22655 | office: 540-508-4539 | fax: 540-508-4441

AUTHORIZATION FOR USE/DISCLOSE OF PROTECTED HEALTH INFORMATION TO SCFM CONVENIENCE CLINIC, PLLC

Patient's Name_____**Patient's ID Number**_____

Street Address _____ **Patient's Date of Birth**_____

City _____**State** _____ **ZIP** _____ **Phone**_____

I authorize **SCFM Convenience Clinic, PLLC, 160 Warrior Drive, Stephens City, VA 22655** to disclose the above-named individual's health information as follows:

❑ Problem List/Core Data Sheet

❑ Medication List

❑ List of Allergies

❑ Immunization Record

❑ Other Physician/Hospital Records from:

❑ Laboratory Results - Dated_____to _____

❑ X-ray Reports - Dated_____to _____

❑ Other _____

❑ Most recent History & Physical

❑ Most recent Progress Note/Office Visit

❑ Consultation Reports

❑ Entire Record

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following person or organization:

_____

Name of Person/Organization authorized to release the protected health information.

_____

Street Address

_____

City, State, ZIP

Phone Number _____ Fax Number_____

Would you like to receive the requested health information electronically on a disk? ❑ Yes ❑ No

If yes, what format would you like to receive the health information ❑ Human readable file (RTF) ❑ CCD file (able to upload into another EHR)

This disclosure and use is for the following purpose(s):*

_____

_____

(* Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.)
I understand that if I give permission, I have the right to change my mind and **revoke** it. This must be in writing to SCFM Convenience Clinic, PLLC that maintains the individual's records that I authorized on Page 1 of this form. I also understand that any uses or disclosures already made with my permission cannot be taken back. If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims. Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

Date, Event or Condition _____

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. By signing this Authorization, 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 privacy rules. I further understand I may request a copy of this signed Authorization. I may inspect or copy any information used or disclosed under this agreement. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be disclosed and would no longer be protected by these regulations.

_____

Patient's Signature or Patient's Representative **Date**

_____

Printed Name of Patient's Representative **Relationship to Patient**

Our Privacy Officer can be contacted as follows:

Monica Hott
SCFM Convenience Clinic
160 Warrior Drive
Stephens City, VA 22655
540-868-4100 • 540-868-0888 fax

SCFM Convenience Clinic, LLC Medicine Use Only

This authorization was revoked:

_____

Signature **Date**