AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

(Not valid for research, marketing, or psychotherapy notes' requests)

Section 1 - Patient Information:

Last Name:_____ First Name:_____ Middle:_____

Other Name Used:_____ Date of Birth:_____

Address:_____ City:_____ State:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Section 2 - Record Request:

I hereby request access to the protected health information in my medical record from _____ to _____ maintained or created by the following clinic &/or provider: (required) _____

(check all that apply-required)

- ☐ Most Recent Progress/Office Visit Notes
- ☐ Pathology/Lab Reports
- ☐ X-Ray Reports/Films
- ☐ Pharmacy
- ☐ Occupational Health
- ☐ Workers Compensation
- ☐ MVA
- ☐ Discharge Summaries
- ☐ Immunization Records
- ☐ HIV/AIDS Treatment
- ☐ Drug & Alcohol Treatment
- ☐ Sexually Transmitted Disease Treatment
- ☐ Mental Health Services
- ☐ Entire Health Record
- ☐ Billing Records
- ☐ Other_____

Section 3 - Recipient Information

- ☐ I will pick up copies of my record
- ☐ Mail Copies of my record to the individual/entity noted below
- ☐ Fax my records to individual/entity below
- ☐ Provide my records in electronic form to individual/entity noted below

Records To:
Name: Coze Health Medical LLC
Address: 156 Sagamore Pkwy W, Ste A, West Lafayette, IN 47906
Phone: 765-204-1122 Fax: 765-205-8322
Email Address: info@cozehealth.com

Purpose of Request **(required) :**

☐ Patient's Request ☐ Legal ☐ Insurance ☐ Continuing Care ☐ Other:_____

I **understand:**

- I may revoke this Authorization at any time by providing my written revocation to: COZE Health Privacy Officer, 156 Sagamore Pkwy W, Ste A, West Lafayette, IN 47906. The revocation will not apply to information that has already been released in response to this Authorization . Unless sooner revoked, the automatic expiration date of this Authorization will be three (3) years from date of signature. Otherwise, this authorization will expire on (Date):_____or a defined event:_____.
- The information in patient's health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- After the above information is disclosed, it may be re-disclosed by the person or agency that received it, and the information may not be protected by federal privacy laws or regulations.
- Authorizing the use or disclosure of the information identified above is voluntary. This form is not required in order for a patient to receive health care treatment, payment, enrollment or eligibility from benefits.
- I have a right to receive a signed copy of this authorization form.

_____ _____

Signature of Patient, Parent or Authorized Representative

Relationship to Patient

Print Name of Patient , Parent or Authorized Representative

For Office Use Only
Date

Secondary Approver Signature_____ Date_____