Authorization for Release of Individually Identifiable Health Information via Email

MRN: ___________

Patient Name: _________________________________ **DOB:** _____/_____/_____ **Phone:** (_____) _____-_________

Email Address: ____ **Please Print Clearly. If we cannot read your email address, we will not send your records.**

Holston Medical Group uses a contracted release of information (ROI) vendor and fees are associated for copies of medical records unless sent to another healthcare facility for continuation of care. All fees are billed by the ROI vendor.

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary. I also understand the disclosed information may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I also understand that there will be fees associate with any release of information that is not sent to another healthcare facility as continuation of care.

Please be advised that our email may not be encrypted and secure therefore be at risk of being accessible by unauthorized individuals. By checking the box below, you are acknowledging that you have been made aware of these risks and give your permission for this office to email your protected health information to the email address you have provided above.

☐ **I acknowledge that I have been notified of the risk of unencrypted email.**

Please Check All That Apply:

****Information to be Released:**	****Information will be used/disclosed for the following purpose(s):**
______ Immunization Record	______ Continuation of Care (for another Provider)
______ Office Notes – Specific Date of Service: _____/_____/_____	______ Personal Use
______ Radiology Reports – Specific Date of Service: _____/_____/_____	______ Other:______________________________
______ Lab Results – Specific Date of Service: _____/_____/_____	
______ Other: ____	

The patient or the patient's representative must read and initial the following statements:

_____ 1. I understand that the information in my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about psychiatric services, and treatment for alcohol and drug abuse.

_____ 2. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

_____ 3. I understand that I may revoke this authorization at any time by notifying *HMG* in writing. If I do revoke the authorization, it will not have any effect on any actions taken by *HMG* prior to their receipt of the revocation. Unless otherwise noted, I understand this authorization will expire 90 days from the date of my signature.

____ ______/_______/__________________

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

____ _______________________________

Printed name of Patient or Patient's Representative **Relationship to Patient**

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
ان ت باه : إذا ك نت ب حاجة إل ى خدمات ال ل غة أو ال ترجمة، ي رجى أن ت ط ل ب ال تحدث مع مدي ر م ك تب .

For Internal Use Only: Photo ID provided ______Yes ______No Attach a copy of the Photo ID or form used to validate the signature. **1/2/2018**