STAR Health UNIVERSITY of DELAWARE | Nurse Managed Primary Care Center

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I am a current patient of ("The Practice"): _____ **Phone number of provider:** _____

Address of practice/provider: _____

By signing below, I authorize the Practice to disclose my protected health information ("Information"). I understand that signing this Authorization is **voluntary**.

Send Information to: Nurse Managed Primary Care Center at the University of Delaware

Address: 540 South College Avenue, Suite 130; Newark, DE 19713

Fax # 302-831-3193 **Phone #** 302-831-3195

Purpose of Disclosure (*Check one*)

❑ Transfer medical care ❑ Coordination of care with other medical provider

Other (specify):

Information to be Disclosed: (for past year only)

❑ Entire Medical Record OR just items checked ❑ Lab & Test Results ❑ Diagnostic Reports ❑ Consultant Reports ❑ Other (list)

Are there date restrictions on the Information to be disclosed?

❑ No ❑ Yes (specify the timeframe of the records)

The patient agrees with the following statements:

I understand that the patient's health care and the payment for his/her health care will not be affected if this Authorization is not signed.

I understand that this Authorization will expire in one (1) year, unless sooner revoked.

I understand that I may revoke this Authorization at any time by notifying the Practice in writing, but if I do, it will not have any effect on any actions taken before the Practice received the revocation.

I understand that there is potential that the recipient of the Information may redisclose the Information and the Information may no longer be protected by federal or state privacy laws.

I understand that the Information disclosed may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, hepatitis C or genetics. If you do not wish for this specific information to be disclosed, please describe the specific information to be excluded:

Patient Name (Printed) _____ DOB: _____

Patient Signature _____ Date: _____

The Practice will not disclose any Information unless this form is filled out completely and signed.