APPLEBY & CO.
INC

Authorization for Use or Disclosure of Health Information

I AUTHORIZE_____
(Name of physician or health care provider authorized to use or disclose information)

TO DISCLOSE TO_____c/o Appleby & Company
(Name of person/organization to which disclosure is made)

PATIENT INFORMATION
Patient Name (list other names used) _____
Medical Record No_____ **Social Security No.**_____
Date of Birth_____ **Telephone No.**_____
Address_____

TYPE OF INFORMATION TO BE RELEASED

☐ Any and all Records - from:_____ to:_____ (unless otherwise stated)

☐ Medical Records relating to injury_____ (DOI) ☐ Consultation Reports

☐ Laboratory, Pathology Reports ☐ Radiology Reports/Imaging Reports

☐ Immunization Records ☐ Progress Notes ☐ Billings

☐ Other:_____

FOR THE PURPOSE OF

☐ Medical ☐ Legal ☐ Insurance ☐ Personal ☐ Other:_____

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for: **(check boxes and initial)**

☐ Mental/Health/Psychiatric Disorders_____ (initial)

☐ HIV/AIDS virus_____ (initial)

☐ Drug, Alcohol Abuse/Treatment_____ (initial)

☐ Sexually Transmitted Diseases_____ (initial)

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DURATION/REVOCATION/RIGHTS

I understand that I have a right to revoke this authorization at any time. I understand that my revocation must be in writing and presented to the Health Information Management Department. I understand that the revocation will not apply to information that has already been 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 will expire on the following date event or as specified:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from date of signature.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. 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 redisclosure, and the information may not be protected by federal and state confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information. I understand I have a right to receive a copy of this authorization.

A carbon copy, photo static copy or thermo fax copy of this true release shall be as valid as the original.

_____ _____

Signature of Patient, Parent or Legal Guardian *Date*

_____ _____

If signed by other than patient, indicate relationship *Date*

_____ _____

Witness Signature *Date*