Matthew N. Klain, MD., P.C.

PATIENT AUTORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Information to be released to:

Matthew N. Klain, MD, P.C.
IRMC Chestnut Ridge
25 Colony Blvd, Suite 102
Blairsville, PA 15717
P: (724) 459-9111 F: (724) 459-7856

Name of Patient:_____

Address:_____

_____

Birth Date:_____

I authorize _____ to release my health information including records concerning psychiatric, alcohol and drub abuse; and HIV related information for the purpose of:

(Continuity of care, disability determination, insurance claim, legal matter, etc.)

I understand the following:

a. That I may inspect or copy the protected health information describes by this authorization.
b. That this authorization may be revoked in writing and delivered to the contact person at the office although revocation will not be effective as to the disclosure if records whose release I have previously authorized, or where action has been taken in reliance on an authorization I have signed.
c. That information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
d. That Matthew N. Klain, MD, P.C. shall not condition treatment, payment or enrollment in their facilities on my providing authorization for the requested use of disclosure.
e. If the only reason I have asked IPG to provide a health care service is so that we can create information to be disclosed to a third party, we may refuse to provide the service if you refuse to sign this authorization. For example, if you have requested a drug test solely for the purpose of having the results disclosed to your employer, we may refuse to perform the drug test if you refuse to sign this authorization permitting us to disclose the results to your employer. Otherwise, your ability to receive treatment, payment, and enrollment in a plan or eligibility for a benefit does not depend on you signing this form.

This authorization expires:

a. On the following date: _____ (if no date or event is stated, expiration is 90 days from the date it was signed)
b. When the following event occurs:_____

Signature of Patient or Patient Representative_____

_____ _____

Witness Date

The above individual is unable to consent because (check one):

☐ Minor ☐ Incompetent ☐ Other (explain)

Oral Authorization

I understand that the person understood the nature of this release and freely gave his/her oral consent.

_____ _____

Witness Date Time

_____ _____

Witness Date Time