Nectar Health Alliance

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: Caresa Zohrert | Date of Birth: 12/29/1966 | MR# (Staff to Complete):

Phone: 280-239-4228 | Address: 46 State St., Black Lake, QC G6H 7H6

I would like to receive these records via ☐ Fax ☐ CD ☐ Paper ☑ Email | Email Address: c.zohrert@examplemail.com

RELEASE MEDICAL RECORDS FROM:

Facility or Name: Wellness Medical Facility

Address: 519 Gateu St.

City/ST/Zip: Watermook, QC G1L 2E4

Phone #: 225-281-9247 Fax:

DISCLOSE MEDICAL RECORDS TO:

Facility or Name: Servograd Institute

Address: 582 S. Tallwood St.

City/ST/Zip: Boiestown, NB E6A 4G4

Phone #: 668-160-2128 Fax:

I AM REQUESTING MEDICAL RECORDS FOR DATES:

FROM: _____ TO: _____ ☑ ALL

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws. CZ (please initial)

INFORMATION TO BE DISCLOSED (please specify):

☐ I am requesting records from a specific department

Department Name: _____

- ☑ Entire Inpatient Medical Record
- ☑ Entire Outpatient Medical Record
- ☐ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ Labs/Pathology Reports
- ☐ Pathology Slides/Blocks
- ☑ Imaging Reports (x-rays, MRI, etc.)
- ☐ Imaging Films
- ☐ Echocardiogram Tapes
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☑ Medications
- ☐ Billing Statement
- ☐ Verbal Communication
- ☐ Other (specify below):

Your initials are required to release the following:

- _____ Psychiatric/Psychology Notes
- _____ Psychological Evaluations& Results
- _____ Genetics Testing
- _____ HIV Lab Reports
- _____ Drug/Alcohol Results
- _____ STD Information

Please Note: Some of these items may require signature of the minor

PURPOSE OF DISCLOSURE (please specify):

☐ Continuing care with another physician or hospital

☑ Transfer of Care ☐ Personal Copy ☐ Other: _____

EXPIRATION DATE OR EVENT:

(If left blank, this Authorization expires 90 days from the date signed)

Specify a date or event: _____

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying the "Sent FROM" organization noted above in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
4. I have the right to inspect or copy the information to be used/disclosed as permitted by federal law.
5. I may refuse to sign this authorization and that it is strictly voluntary.
6. If I do not sign this form, my health care and the payment for my health care will not be affected.
7. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

Patient/Guardian/Representative Signature: [signature] Date: 5/28/2023

Patient/Guardian/Representative Printed Name: CARESA ZOHRERT Relationship to Patient: _____