

**AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED
HEALTH INFORMATION**

I hereby request and authorize _____ (the name of the hospital, or physician name if requesting release from a physician's office) to use or disclose medical records as described below.

Purpose of Use or Disclosure: ☒ At the request of the individual
☐ Other _____

Patient's Full Name: _____

Maiden/Other Name: _____ SSN: _____

Date of Birth: _____ Telephone Number: _____

Current Address: _____

I further request and authorize use or disclosure of the medical records checked below to (please provide name and address or class of persons):

LATEISHA JACKSON-BROWN, DIRECTOR OF JEREMY'S PLACE, INC.

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information STD/HIV/AIDS information and/or information regarding alcohol or substance abuse.

<input type="checkbox"/> Entire Medical Record*	<input type="checkbox"/> Discharge Summary Reports	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Abstract of Record**	<input type="checkbox"/> Doctors Orders	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Financial Record	<input type="checkbox"/> Electro Cardiogram (ECG/EKG) Reports	<input type="checkbox"/> PT/OT Notes
<input type="checkbox"/> Pathology Slides/Blocks	<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Radiology Films	<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Speech - Language Reports
<input type="checkbox"/> Ambulance Record	<input type="checkbox"/> Gastro Intestinal (GI) Lab Report	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Autopsy Record	<input type="checkbox"/> History and Physical Report	<input type="checkbox"/> Diagnostic Photos _____
<input type="checkbox"/> Cardiac Cath Report	<input type="checkbox"/> Laboratory Test Results	<input type="checkbox"/> Other COVID-19 TEST RESULTS _____
<input type="checkbox"/> Consent Forms	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Notes _____
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Neurodiagnostic Reports	

* Entire Medical record includes all items not in bold print.

** An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has take action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. The medical provider shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research -related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here** _____.

Patient's or Legal Representative's Signature

Please Print Name

Today's Date

As Legal Representative, my relationship to the patient is _____
Any document outlining such authority should be attached. The patient is unable to sign because _____