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: _X_ 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*):
LATIESHA 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.

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