Faith Hackett M.D./Jacalyn Ginsburg, D.O.

Patient Name (Print) Patient DOB

_____ I authorize Dr. Hackett/Ginsburg to release/disclose my health information as described below.

Please select one of the following options:

☐ A full summary of my medical records + the last three years

-OR-

☐ A full summary of my medical records + the last five years

-OR-

☐ My full medical record

Please initial each item below to indicate your understanding.

_____ I understand that there may be a charge for processing my records.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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.

_____ I understand that it may take up to 21 days before my record is available and ready for pick up at Dr. Schmidlein's office.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____ Fax #:_____

Address: _____

City:_____State_____Zip:_____

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve 12 months from the date on which it was signed.
.

_____ _____/_____/_____

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

_____ _____/_____/_____

Witness Signature Date

Distribution of copies: original to practice, copy to patient, copy to accompany information released