AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORD RELEASE
TO JYI FROM ANOTHER FACILITY/PROVIDER

AT MY REQUEST, I AUTHORIZE:

Name/Institution: _____
Address: _____
City, State, Zip: _____
Phone Number: _____ **Fax Number:** _____

TO DISCLOSE THE FOLLOWING INFORMATION:
(description of individual health information to be disclosed)

- **Any and all medical records pertaining to the treatment of the individual seen on or about** _____
- **Other (specify)** _____

PLEASE MAKE DISCLOSURE TO: JORDAN-YOUNG INSTITUTE
5716 Cleveland Street, Suite 200
Virginia Beach, VA 23462
Ph: (757) 383-6628
Fax: (757) 578-5995

PURPOSE OF DISCLOSURE: _____
_____

- I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.
- I understand that I have the right to revoke this Authorization at any time, except to the extent that action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above. (The written revocation must be legible and include the name and date of birth of the individual, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to receive the information, the signature of the person with legal authority for authorization/revocation, and their phone number).
- I also understand that 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 I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition: _____

I certify that I am the patient or legal guardian with the authority to authorize disclose of this individual's protected health information.

Patient Name: _____ DOB: _____

MR#: _____ SSN: _____

Signature: _____Date: _____