PCM CORRECTIONAL HEALTH CARE, INC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ SSN: _____
Address: _____ Date of Birth: _____
_____

I hereby authorize **PrimeCare Medical, Inc.** d/b/a **PCM Correctional Health Care, Inc.** at the _____ (facility) to release copies of the portions of my health records described below to _____, for the following purposes: _____
_____

Specific Information Covered by this Authorization

THE FOLLOWING INFORMATION IS SPECIALLY PROTECTED BY FEDERAL AND STATE LAWS. IF ANY OF THIS INFORMATION APPLIES TO YOU, PLEASE INDICATE ANY OR ALL OF THE INFORMATION YOU WOULD LIKE TO MAKE SUBJECT TO THIS AUTHORIZATION:

( ) Alcohol/Drug Abuse Records ***** Additional Form Required (H-RR2)*****
( ) Mental Health Records _____ *Initials*
( ) HIV Related Info. _____ *Initials*

( ) Discharge Summary ____ Initials
( ) History/Physical Info. ____ Initials
( ) Laboratory Studies ____ Initials
( ) X-ray Reports ____ Initials
( ) Operative Reports ____ Initials
( ) Pathology Reports ____ Initials

Date(s) of Service and/or medical Information specific to this request: _____
_____

This Authorization will expire one (1) year from the date that I sign it. I understand that I may revoke this Authorization, in writing, at any time. I also understand that my revocation of this Authorization will not impact any action taken in reliance on this Authorization prior to PCM's receipt of my written revocation.

I understand that my treatment may not be conditioned on my agreement to sign this Authorization. I also understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the persons listed above and may no longer be protected.

I understand the nature of this Authorization.

_____ _____
Patient Signature *Date*

If the above signatory is a personal representative, their legal relationship to the patient/client is: _____
_____

Signature of staff person obtaining authorization: _____

If this Authorization authorizes the release of Mental Health Records or HIV-related information, the following statement must be included with the information being released:

This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws. These laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the patient to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.