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PROTECTED HEALTH INFORMATION RECORDS RELEASE FORM

I authorize use or disclosure of the named individual's health information as described below:

Patient Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

The following individual or organization(s) is authorized to make the disclosure.

___Stephen R. Burton MD, P.C. to **receive** information from: _____

_____

___Stephen R Burton MD, P.C. to **send** information to:_____

_____

Itemize records to be copied:_____

_____

_____

_____

There will be a charge of $_____ for copying records for use other than sending information to another physician.

SENSITIVE INFORMATION: A separate written consent is required to release information regarding HIV/AIDS status or substance abuse unless so ordered by a court.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

OTHER RIGHTS: (A) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (B) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____(If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

Signature of patient or legal representative:_____ Date:_____

If signed by legal representative, relationship to the patient:_____