STONE MEDICAL, PC

DAVID SCOTT JONES, MD, PC

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME:______________________________DOB:_______________PHONE:___________________

ADDRESS:____

- ☐ By signing, I authorize Stone Medical, PC to DISCLOSE / RECEIVE certain protected health information about me TO / FROM
- ☐ By signing, I authorize David Scott Jones, MD, PC to DISCLOSE / RECEIVE certain protected health information about me TO / FROM

NAME:______________________________________ADDRESS:____

PHONE:_____________________FAX:__________________REASON FOR DISCLOSURE:________________________________

This document will authorize you to provide or receive a copy, summary, or narrative of my medical record (as indicated by the check mark(s) below) or to otherwise release or receive confidential information. At this time I am requesting the following:

- ☐ COMPLETE RECORD- Progress Notes/Labs/Diagnostics
- ☐ RECORDS OF CARE FOR DATES OF SERVICE: FROM:___________________TO:___________________

_____ PROGRESS NOTES _____ LABORATORY REPORTS _____ IMMUNIZATION RECORDS

_____ PATHOLOGY REPORTS _____ IMAGING REPORTS/SPECIFY:___________________________

RECORDS OF CARE CONCERNING PROTECTED OR SENSITIVE INFORMATION:

- ☐ By initialing I consent to the release of any positive or negative results associated with the following tests and information, with the rest of my medical records.

_____ GENETIC TESTING _____ DRUG AND ALCOHOL TESTING AND/OR USE

_____ MENTAL HEALTH _____ HIV/AIDS/STD TEST RESULTS

RECORD FEES

_____ No Payment Required _____ Patient Payment Required: $________

I understand that Stone Medical, PC and David Scott Jones, MD, PC cannot release any protected health information (labs/diagnostics/chart notes/consults/referrals/medical history) received from other providers or medical services. I do not have to sign this authorization in order to receive treatment from Stone Medical, PC or David Scott Jones, MD, PC. I have the right to refuse to sign this authorization--it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA rule. I have the right to revoke this authorization, provided I do so in writing. If I revoke my authorization, Stone Medical, PC and David Scott Jones, MD, PC will no longer use or disclose information. I understand that the clinic cannot take back any usages or disclosures already made prior to the revocation.

SIGNED BY:____/________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_______________________________________/______________________________/____________________________

PRINT PATIENT'S NAME PRINT NAME OF LEGAL GUARDIAN RELATIONSHIP TO PATIENT