OCH Medical Associates
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AUTHORIZATION FOR DISCLOSURES OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Patient Number:_____

Date of Birth:_____

I hereby authorize **any and all healthcare providers** to use or disclose my protected health information covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 to **OCH Medical Associates,** for the following purposes: **treatment and continued health care .**

List dates and information to be used or disclosed: **any and all medical records.**

I hereby authorize/grant _____
_____
To have access to my medical records anytime and/or when necessary

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released will not be covered under the federal privacy laws.
- **OCH Medical Associates** will provide the patient/organization with a copy of the confidential healthcare information for which this authorization is being sought.
- The patient is voluntarily signing this authorization.
- The patient reserves the right to refuse to sign this authorization.
- The patient reserves the right to revoke this authorization at any time. This revocation must be in writing and shall not be effective with respect to any use or disclosure made by the Hospital in reliance on this authorization prior to the date of the Hospital's receipt of my revocation.
- The patient may receive a copy of the signed authorization.

This authorization will expire **annually.**
I certify that I am the patient listed above or a person authorized to permit release of records on patient's behalf. I hereby release **OCH Medical Associates** from any liability arising in connection with the use or disclosure of my protected health information pursuant to this authorization.

Patient/Legal Representative:_____ Date:_____

Basis of authority to sign for patient:_____