Consent for Release of Health Information

Person(s)/Organization(s) authorized to disclose/release information:

Name:___HolladayMD/Dr. Holladay_____

Address:___865 E 4800 S, Ste 160_____

City/State/ZIP:___Murray, UT_____

Telephone: _(385) 251-6028 fax: (801)-262-1844

Person(s)/Organization(s) to whom information may be disclosed:

Name:_____

Address:_____

City/State/ZIP:_____

Telephone: _____

Specific information to be used/disclosed:

Progress notes, other notes, diagnostic test results, or other verbal or written information (including, but not limited to, forms) related to medical condition.

This information does not include psychotherapy notes. It includes all information within the records listed above related to mental health, substance abuse, HIV/sexually-transmitted diseases, and genetic testing (including, but not limited to, information relating to treatment, prevention, history, or assessment of these issues), unless specifically noted here:_____

(Excluding specific types of information may prevent certain records from being released. This permission may be revoked at any time except to the extent a person/organization authorized to make the disclosure has already relied on it.)

Purpose(s) of the disclosure: Disability-related proceedings, administration of disability or unemployment-related benefits, or FMLA or medical leave-related proceedings

Date or event upon which this authorization will expire:_____

(If no date is provided, the authorization will expire one year from the date this form is signed.)

This authorization may be revoked (taken back) in writing at any time. This may be done by providing a written statement to the disclosing organization or person, stating that you wish to revoke this authorization. This revocation will not apply to the extent that the covered entity (or person making the disclosure) has already taken action relying on this authorization or in certain cases where the authorization was obtained as a condition of obtaining insurance coverage. If a person/organization listed above is a covered entity under HIPAA (an organization required by HIPAA to protect health information – this includes Dr. Holladay, HolladayMD), they may not condition treatment, payment, enrollment, or eligibility of benefits on whether this authorization is signed. An exception may apply in which an insurance company (or health plan or government program that provides health benefits) may refuse payment or eligibility for benefits (or your case may be reviewed but found to have insufficient information to support your claim) if you decide not to permit release of your health information. Once this information is disclosed to the recipient, there is the possibility that it may be re-disclosed and/or may no longer be protected by HIPAA regulations.

_____ _____

Patient signature Date

_____ _____

Patient name Birth date