MANDATORY

SIMMONS CLINIC
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RELEASE OF PROTECTED HEALTH INFORMATION REQUEST FORM

TO BE COMPLETED BY THE PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE:

Patient's Name:_____

Social Security #_____ DOB:_____

Street Address: _____

_____

_____

City State Zip Code

Telephone:_____

I hereby authorize release of my confidential health information to Dr. John C. Simmons of the Simmons Clinic from the following health care facility/physician:

Health Center:_____

Address:_____

Telephone/Fax:_____

My authorization is for the use and disclosure of the following records

_____ Statements of charges/payments

_____Record of office visits

_____ Mental Health Information

_____ STD Information

_____ ALL Radiology/Lab reports

_____ALL of the above information

_____Verification/Explanation of ALL Medical Conditions

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My authorization pertains to information generated on the following date(s) or in the following time period: _____.

My authorization is given freely and I understand that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Simmons Clinic may not condition my treatment on my provision of this authorization.
- This authorization is good for a 365 day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as VALID as the original.
- Simmons Clinic, its directors, officers, employees, agents, and volunteers are hereby released from any legal responsibility or liability of disclosure of the above information to the extent indicated and authorized therein.
- I acknowledge that I have received a copy of the HIPAA regulation.

This authorization will expire on:_____

_____ _____

Patient's Signature Date

_____ _____

Signature of Parent/Authorized Representative/Witness Date

CONFIDENTIALITY NOTICE: The attached information to this facsimile transmission is **CONFIDENTIAL** and is intended only for the use of the recipient(s) identified above. It may contain confidential and protected health information subject to privacy regulations such as Health Insurance Portability and Accountability Act of 1996 (HIPPA). If you are not the intended recipient or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is **STRICTLY PROHIBITED.**