J. David Gibeault, M.D., P.C.
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ Date of Birth: _______________
Address: ____________________________________City_____________________State_______ Zip_______
Telephone: _____________________ SSN:__________________________________

1) I authorize the following organization or facility named:__ J David Gibeault, M.D., P.C.
3100 N. Campbell Ave. Ste# 102
Tucson, AZ 85710

2) To disclose protected health information to:*(Name and address of recipient)* *MAIL to below address:*

Name: ____
Address: ____City_________________ State_______Zip________
Covering period(s) of health care From (Date)________________________ To (date) _______________________

3) Information to be disclosed: ❑ Complete written health record(s) (**OR**) Select information as checked below:

❑ Office Notes
❑ Laboratory Tests
❑ Consultation Reports
❑ Photographs videotapes, digital/other
❑ Procedure Reports
❑ X-ray Reports
❑ Itemized Bill
❑ X-Ray films/images
❑ Other (please specify):
____

4) Purpose or Description of how information will be used: ❑ Continuing care ❑Changing Primary Physician ❑ Legal
❑ Personal ❑ Other ____

5) I understand that this may include information relating to the following and *I agree to* its release unless I indicate NO.
Initials required.
YES____/ NO____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
YES____/ NO____ Behavioral Health care
YES____/ NO____ Treatment for alcohol and/or drug abuse
YES____/ NO____ Genetic Counseling, testing.

6) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken based upon the authorization.

7)

8) Unless otherwise revoked, this authorization will expire after 60 days from this date of request. _____________________
____

9) The facility releasing the above records as requested is released from any legal liability for disclosure of my protected health information to the extent authorized by this form.

10) I understand that J. David Gibeault, MD, will not condition treatment or payment on obtaining this authorization, except where federal law allows such condition.

11) I understand that if the organization authorized to receive the health information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

12) I understand there may be a fee for copying these records for personal use. In addition, access by review of the original record will have a fee and a time limitation.

____
Signature of Patient or Legal Representative Date Signature of Witness Date

Printed Name of Patient's Representative: ____

Relationship to or authority to act for the patient: ____

Note: If the patient is unable to consent by reason of age or some other factor(s), state reason:
____
____

Original: Patient's PHI Record
Copy: Patient/Representative

All Highlighted questions MUST be answered by patient/representative
General Release of PHI Authorization Form