3C Patient Advocacy
Competence
Compassion
Care

3C Patient Advocacy, LLC
7 Ave de Lafayette #121137
Boston, MA 02112

617 221 4499 - p
857 343 8127 - f
hbkummer@3CPatientAdvocacy.com
3CPatientAdvocacy.com

Authorization for Use and Disclosure of Health Information

Patient Name_____ DOB_____ Date_____

Address_____ Phone_____

I authorize _____

To share my protected health information with:
Heidi B. Kummer MD, 3C Patient Advocacy, LLC _____

Information that may be released:

( ) I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of drug or alcohol abuse).

OR

( ) I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify) _____

This authorization covers the period of healthcare from: _____ to _____

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.
This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on the authorization; I have a right to inspect and receive a copy of the material to be released; I have the right to request restrictions on how my health information is used and disclosed.

_____ _____
Participant's signature or oral consent when physically unable to sign Date

_____ _____
Signature of authorized person in lieu of participant Date

_____
Authorized person printed name
( ) Power of Attorney; ( ) Spouse; ( ) Health Care Proxy; ( ) Other _____