Irina Jasper M.D. AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION **Note: Fees may apply to certain requests**	Patient Name: _____ DOB: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Telephone:_____ Email: _____ MR# (Office Use Only) _____

Treatment, payment, enrollment or eligibility benefits will not be conditioned on my providing or refusing to provide this authorization.

This authorizes Irina Jasper M.D. to release information to:	**This authorizes my Medical Records to be released from:**
Recipient Name: _____ Address: _____ City: _____ State: _____ Zip Code:_____ Telephone: _____ Fax: _____ Delivery Preference: ☐ Mail ☐ Pickup ☐ Fax ☐ Verbal	Name: _____ Address: _____ City: _____ State: _____ Zip Code:_____ Telephone: _____ Fax: _____ **and delivered to Irina Jasper M.D. as specified below.**

PURPOSE: The health information disclosed may only be used for the following purposes:

_____

FOR ☐ COPIES – OR – ☐ VERBAL, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

☐ Medical Record …….. dated from _____ to _____
☐ Specific Injury/Treatment: _____ dated from _____ to _____
☐ X-Ray: ☐ Images and/or films ☐ Reports Describe:_____
☐ Laboratory Results …….. dated from _____ to _____
☐ Other (specify): _____ dated from _____ to _____
☐ Protected Minor Records (Adolescent Confidential 12-17 years old).

NOTE: Medical records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records will not be disclosed unless specifically requested below.

Signatures and dates required if any of the following boxes are checked

☐ Mental Health dated from _____to_____ Signature: _____Date: _____
☐ Alcohol/Drug dated from _____to_____ Signature: _____ Date:_____
☐ HIV Test Results dated from _____to_____ Signature: _____Date:_____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____

Date **Signature** **If not patient, print your name and relationship**