CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete a separate form for each patient

PATIENT INFORMATION AND CONSENT

Name ____ Date of Birth _______________

Mailing Address ____

Primary Phone No. _____________________ Alternate Phone No. _______________

I hereby authorize American Medical Center to release and disclose my protected health information to:

Name ____ Date of Birth _______________

Mailing Address ____

PROTECTED INFORMATION TO BE SHARED (*please check one)*

☐ All information (including personal, health, demographic, claims, billing and medical records)

☐ Only limited information (*please describe)* ____

RELEASE OF HIGHLY PROTECTED HEALTH INFORMATION (*please check all that apply)*

I hereby authorize the release of the following highly protected information:

☐ Substance abuse records (including alcoholism)

☐ AIDS or HIV treatment records

☐ Mental health services (does not include psychotherapy notes)

☐ DO NOT release any of the above highly protected health information

EXPIRATION AND CANCELLATION (*please check only one box)*

This consent will expire on*:*

☐ On this date (MM/DD/YYYY) __________________________________

☐ When canceled in writing, or upon my death

AUTHORIZATION AND SIGNATURE

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and may then no longer be protected by federal or Guam privacy regulations.

I understand that I have the right to revoke this consent at any time. I further understand that any action already taken prior to any revocation of consent cannot be reversed, and my revocation will not affect those actions. I can revoke my consent by writing to:

American Medical Center
1244 N. Marine Corps Drive
Tamuning, Guam 96913
Attn: Privacy Officer

I allow the use and disclosure of my protected health information as described in this document. This information is being released at my request. I understand that treatment, payment, enrollment or eligibility for services does not depend on whether I sign this authorization.

Patient/Guardian/Authorized Representative Name____

____ ________________________

Patient/Guardian/Authorized Signature Date