MedExpress

Authorization for Release of Protected Health Information

Patient Name:		DOB:			
Address					
City		State:		Zip	

I hereby authorize MedExpress, located at _____, to use and/or disclose the above-named individual's protected health information as described below, for the period of _____ to _____.

- ☐ History and Physical Examination
- ☐ Consultation Reports
- ☐ X-ray and Imaging Reports
- ☐ Medication Sheets
- ☐ Other (describe): _____
- ☐ Complete health records without limitation
- ☐ Staff/Physician Progress Notes
- ☐ Pathology Reports
- ☐ Laboratory and/or Test Results

This information may be disclosed to and used by the following:

Name of Person or Institution:					
Address:					
City:		State:		Zip:	
Phone:		Fax:			

This information may be used for the purpose of: _____

I specifically authorize the release of any and all information relating to:

- ☐ Mental Health
- ☐ Alcohol and Drug Abuse (or SUD)
- ☐ Child, Domestic and Other Abuse
- ☐ Genetic Information
- ☐ Sexually Transmitted Disease (STC)/Sexually Transmitted Infection (STI)
- ☐ HIV and AIDS (in some states, this may include a test even if negative)
- ☐ Fertility, pregnancy, abortion and reproductive health and sexual assault/rape

I understand that I have a right to **REVOKE** this authorization at any time. I understand that if I revoke this authorization I must do so **in writing** and must present my written revocation to medexpressrequest@optum360.com or fax it to 1-888-409-2801. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration event or condition, this authorization will expire in six (6) months, except to the extent that action has been taken thereon.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand MedExpress may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal or state confidentiality rules.

_____ _____

Signature of Individual or Legal Representative | Date

_____ _____

If Signed by Legal Representative, Relationship | Signature of Witness