PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information:

- Full Name: _____

- Date of Birth:_____

- Address: _____

- City, State, Zip Code:_____

- Phone Number: _____

By signing this authorization, I authorize IRIAMAR VELEZ-QUIÑONES, MD to use and/or disclose certain protected health information (PHI) about me to:

Please send the medical records to:

- Name of Recipient: _____

- Relationship to Patient _____

- Organization Name (if applicable): _____

- Address:_____

- City, State, Zip Code: _____

- Phone Number:_____

- Email Address (if applicable): _____

This authorization permits IRIAMAR VELEZ QUIÑONES, MD to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates(s) of services, type of services, level of detail to be released, origin of information, etc.):

Information to be Released:

(Please check one or more options)

☐ Complete medical record

☐ Specific records (please specify): _____

☐ Other:_____

_____

The information will be used or disclosed for the following purpose:

☐ Continuity of Care

☐ Insurance Claim

☐ Other: _____

This authorization will expire on [date]: _____, or defined event.

Right to Revoke:

I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer at: IRIAMAR VELEZ QUIÑONES, MD, Urb. García, 60 Calle 16, Arecibo, PR 00612

Charge:

I understand that there may be a fee for the copies of my medical records, not to exceed $25, as stipulated by law in Puerto Rico. Additionally, if the records need to be mailed, I acknowledge that there may be additional charges for postage.

Signature:

I understand that my medical information is protected under the Health Insurance Portability and Accountability Act (HIPAA) and that my authorization is required for the release of this information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

By signing this form, I acknowledge that I have read and understand the contents of this authorization.

Signed by: _____ Date:_____
Relationship to patient: _____
Patient's name:
_____
Print name of patient or legal guardian:
_____

Kindly include an ID with this request form.