

SNELL FONTUS, M.D., LLC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Snell Fontus, M.D., LLC (the Practice), to use and disclose a copy of the health information described below regarding me, _____, to _____, for the purpose of _____. The health information to be used and disclosed includes the information specifically authorized below as well as all other information in my health records relevant to the above-described purpose.

- ___ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
- ___ By initialing here, I specifically consent to the disclosure of my mental health information.
- ___ By initialing here, I specifically consent to the disclosure of my genetic testing information.
- ___ By initialing here, I specifically consent to the disclosure of my drug and alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Unless revoked earlier, this Authorization shall remain in effect until my death.

Dated _____, 20__

(Print patient name)

Date of Birth: ____ / ____ / ____

(Signature of patient or legal guardian)

(Print guardian name)

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.