Naaman Clinic, LLC
Authorization to Disclose Health Information

Patient Name: ____ DOB: _________________________________

1. I authorize Naaman Clinic, LLC to use or disclose the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   - ☒ Visit Note
   - ☒ Pathology Report
   - ☐ Entire Record
   - ☒ Patient Account Statement/ Billing Records
   - ☐ Other:_______________________________

   Please select how you would like the information sent to you:

   - ☐ Email:________________________________
   - ☐ Pickup at office
   - ☐ Fax:__________________________________
   - ☐ Mail ($5 processing fee)

   Date(s) of Service: ____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization:
   Address: ____
   For the purpose: ____
   ☒ At the request of the individual

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Rodney Collins, Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. 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 federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Rodney Collins, Privacy Officer.

7. **The above documents listed (visit note, pathology report, entire record, patient account statement/ billing records) will be provided to the patient at no charge within 3 weeks of your date of service. Please allow the full 3 weeks before calling our office for information regarding your claim. If patient requires ANY other form of documentation requiring physician statement and signature, there will be a $30 charge. Please allow 2 weeks for return.**

___________________________________	___________________________________
Signature of Patient or Legal Representative	Date
___________________________________	___________________________________
If signed by Legal Representative, relationship to patient	Signature of Witness