P.O. Box 9101
Coppell, TX 75019
www.carenow.com

General Purpose Form
Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Sign and date the form at bottom.

Patient Name:_____ Date of Birth:_____ Age:_____

I authorize *CareNow* to disclose or provide my protected health information to the entity or individual identified below.

Release to (Please print):		Preferred Delivery Method:	
Name:	_____	☐	Mail
Address:	_____	☐	Fax
City, State & Zip:	_____	☐	Pick Up (Clinic)
Phone Number:	_____	☐	Email (Corporate)
Fax Number:	_____	☐	Other:_____
Email Address:	_____		

Information to be disclosed (Check all that apply)			
Dates of treatment:			
☐	Chart Notes	☐	General Billing Ledger (Corporate)
☐	Laboratory Results	☐	Statement of Services
☐	Radiology Report	☐	Insurance Documents
☐	Radiology Images (CD)	☐	Worker's Compensation Forms
☐	EKG	☐	Outside Records
☐	Entire Record (Corporate)	☐	Other:

Purpose of disclosure - Please list the purpose of the disclosure or check patient request.

☐ Patient Request ☐ Other (please specify): _____

Inclusions - I understand the disclosure of individually identifiable health information may include information concerning communicable diseases such as HIV or AIDS testing and/or results, mental illness information (excluding psychotherapy notes), and drug/alcohol/substance abuse information.

Expirations or termination of authorization - This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. A photocopy of this authorization will be treated in the same manner as the original. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. (Please list an earlier expiration if less than one year):

_____

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization, except to the extent that we have taken an action in reliance to the authorization prior to your termination. You may terminate this authorization by submitting a written request addressed to CareNow Privacy Manager, P. O. Box 9101, Coppell, TX 75019.

Redisclosure - We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of CareNow.

Non Conditioning - There is no restriction of your treatment as a condition for signing this authorization.

Patient or Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Internal Use - Released By: _____ Date: _____ Time: _____ Acct #: _____