Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize Agapé Physicians Care, Inc., to Use or Disclose my Protected Health Information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

Patient Name:____
First Middle Last

Address:____ Telephone Number:__________________

____ Date of Birth:________________________

E-mail Address:_______________________________________ SS #: ______________________________

Name of person/facility authorized to **release** the information:______________________________________

Address:____ Telephone Number:__________________

____ Fax:_______________________________

Name of person/facility authorized to **receive** the information: **Agapé Physicians Care, Inc.**

Practice/Provider: ____

Address:____ Telephone Number:__________________

____ Fax:_______________________________

Purpose of Disclosure: ____

Dates of Treatment: ____

Information to be Used/Disclosed (please check all that apply):

□ History and Physical	□ Discharge Summary	□ Operative Report	□ Immunization Record
□ Progress Notes	□ Laboratory Report	□ Radiology Report	□ Entire Medical Record
□ Billing Summary	□ Consultation Report	□ Pathology Report	□ Other (specify)____________________

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility.

Agapé Physicians Care, Inc., may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative, provided that the cancellation is made in writing except to the extent that:

1. **The facility has already acted on your request prior to receiving the request to cancel the authorization; or**
2. **If the authorization was given to release records to your insurance company in order to obtain insurance coverage.**

This authorization will automatically expire in 90 days unless otherwise stated.

Expiration Date: ____________________________________

____ ______________________________
Signature of Patient or Legally Qualified Representative Date

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