AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Todd W. Ulmer, M.D.

I authorize: Todd Ulmer, M.D. to use and disclose a copy of the specific protected health information (PHI) described below regarding:

Patient: _____ **Date of Birth** _____

By marking the boxes below, I specifically authorize the release of the following:

- ☐ Office Chart Notes
- ☐ Physical Therapy Records
- ☐ Diagnostic Reports
- ☐ Surgery Reports
- ☐ Worker Compensation Records
- ☐ X-ray Films
- ☐ Billing Statements
- ☐ Other: _____

I understand that there may be a charge for copying my protected health information.

The purpose of this release is for:

- ☐ Personal Records
- ☐ Follow-up Care
- ☐ Diagnostic Evaluation
- ☐ Legal
- ☐ Reimbursement
- ☐ Other: _____

I authorize the entity listed below to release my PHI		**Please send my PHI to:**	
Name:		Name:	
Street Address:		Street Address:	
City, State, Zip:		City, State, Zip:	
Phone #:	Fax #:	Phone #:	Fax #:
Permission to Fax PHI ☐ Yes ☐ No		Permission to Fax PHI ☐ Yes ☐ No	

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place **my initials** in the applicable space next to the type of information.

_____HIV/AIDS information

_____Mental health information

_____Genetic testing information

_____Sexually transmitted disease information

_____Alcohol/chemical dependency diagnosis, treatment or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information, sexually transmitted disease information and alcohol/chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to disclosure.

I have read this authorization and I understand it. Unless revoked, this authorization expires one year from today.

_____ _____ _____

Signature of patient or personal representative | Date | Relationship