Patient's Name: _____
Last First MI

Address: _____
Street

_____
City State Zip

Date of Birth: _____ Telephone #: _____
Month/Date/Year (Area Code) Number

I,
_____authorize_____
(Patient, Parent, Guardian or Legal Rep.) (Name of Physician/health care provider)

To RELEASE to: *MariMed and* _____ ***(patient name)***

Date(s) of Service: _____

Information pertaining to my identity, diagnosis or treatment. The information to released shall include:

___ Office visit notes (within past two years) re: diagnosis/treatment of:
_____
_____
_____

___ Current Active Problem List
___ Letter from treating physician attesting ongoing treatment for specified condition
___ Medication lists/notes/sheets

To be disclosed for the following purposes(s): _____

I understand that my medical record my contain information that is considered sensitive under law. My check mark(s) below indicate that I **do not** permit information of this type, if it exists, to be released or requested:

___ Psychological/psychiatric conditions
___ HIV/AIDS diagnosis and/or treatment
___ Drug and/or alcohol abuse diagnosis/ treatment

Expiration Date: _____(if blank, one year from date of signature)

Redisclosure of information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit redisclosure.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____
Signature Date Signature of Parent, Guardian or Legal Rep. (if needed)