# MEDICAL RECORDS
# GENERAL AUTHORIZATION FOR RELEASE

**RE: _____ ("Patient")**

**I, the above named Patient*, understand that my signature below gives Christina Meighen, LLC, my health care provider ("Provider") permission, to the extent necessary, to use my medical record/information and to provide access to the same both during and after my treatment by Provider, for the following purposes:**

1) **Providing treatment to me;**
2) **Arranging for payment for my care;**
3) **Conducting "health care operations;"**
4) **Conducting other health care providers' "health care operations," to the extent that they have a treatment relationship with me.**

**I understand that my permission allows the transmission of permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.**

**I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do so.**

**I understand that I have the right to request that Provider restrict the use and disclosure of my medical record / information. If I wish to request a restriction, I will initial the following box:**

❑ **I wish to request a restriction.**

**In this case, Provider will provide a separate form to fill out describing the requested restrictions. Acceptance or denial of my request will also be indicated on the same form.**

**I understand that I have a number of rights identified below (and listed more fully on the "Privacy Notice to Patients" provided to me):**

- ❑ **The right to review, and copy, my medical record**
- ❑ **The right to request the amendment (changing) of my medical record**
- ❑ **The right to grant or deny access to my record to others**
- ❑ **The right to decide how information from my record will be conveyed to others**
- ❑ **The right to complain about how my records are handled, to the Secretary of the U.S. Department of Health and Human Services, and to Provider**
- ❑ **The right to revoke, in writing, any consent that I provide for access to my record**
- ❑ **The right to authorize Provider to give information about my care to relatives or close friends, to the extent of their involvement with my care or payment**
- ❑ **The right to review a record of access to my medical record**

**I understand that I have the right to either grant or deny access to my medical record information if access is requested for any reason not set forth above, or, in most cases, for the release of psychotherapy notes. In these instances, my specific written permission will be sought prior to use or release.**

**I understand that the above-stated policies may be amended, and that I will be provided a revised Privacy Notice if this occurs.**

_____ _____

**Signature of Patient** **Date**

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*** A Patient's Legally Authorized Representative may, with the limits of the Legally Authorized Representative's authority, act on behalf of the Patient.**

**I am a Legally Authorized Representative of the above named Patient and may accept and sign this document in place of the Patient. I have provided documentation of the authority granted to me prior to signing this form. I understand that this documentation will be included in the Patient's medical record.**

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**Name of Legally Authorized Representative (printed)**

_____ _____

**Signature of Legally Authorized Representative (printed)** **Date**

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