Albert T. Domingo, MS, MD, Inc.
3120 Parkway St. N.W. Suite A
Canton, Ohio 44708
330-452-9460
330-452-9520 facsimile

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

SSN: _____ Date of Request: _____

I hereby authorize Albert T. Domingo, MS, MD, Inc. to:

___ **Disclose** the following protected health information:

___ **Receive** the following protected health information:

_____

Please Check All That Apply

___Last two years: Blood work, mammogram, bone density, operative reports, pathology, pap smears, physical exams.

___Operative notes and reports ___Physician's progress notes

___X-Rays (General)

___Lab/test results ___Immunizations

___Entire medical record (Including HIV, AIDS, Alcohol or drug abuse and mental health records)

___Other (please specify)

Purpose of Release. The protected health information will be used or disclosed for the following purpose(s):

___ Ongoing treatment and care

___ Other (please specify) _____

Information to be Sent to/Received From:

Name of physician or facility: _____

Address: _____

Phone Number:_____ Fax Number: _____

Expiration. This authorization will expire in 60 days from the date signed, or will expire on _____ (specific date) or when _____ (an event that relates to the patient or the purpose of the use of disclosure).

Revocation. The patient may revoke this authorization in writing at any time, except to the extent that the Medical Practice has acted in reliance on this authorization. Revocation may be made in writing on a form provided by the Medical Practice and delivered to Albert T. Domingo, MS, MD, Inc. or his designated attorney,

Redisclosure. Information used or disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

Patient's Rights. The patient may inspect or obtain a copy of the protected health information used or disclosed pursuant to authorization and may refuse to sign this authorization. Except where allowed by law, Albert T. Domingo, MS, MD, Inc. will not condition treatment, payment or other health care benefits on the giving of this authorization. The patient shall receive a copy of this authorization upon request.

I understand an acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, an/or alcohol/drug abuse, and /or Acquired Immunodeficiency Syndrome (AIDS), and/or may include the results of an Human Immunodeficiency Virus (HIV) test or the fact that an Human Immunodeficiency Virus (HIV) test was performed. I expressly consent to the release of information as designated above. I understand that I am responsible for any fees associated with processing this request.

_____ _____

Patient or Personal Representative Date

(Personal Representative is a person authorized by law to make health care decisions on behalf of the individual, i.e., parent/legal guardian or Durable Power of Attorney for Healthcare)

_____

Description of Personal Representative's Authority

Charges for Release of Information:

• For a personal copy:	Actual Cost of Postage
1 – 10 pages	$3.35 per page for the first ten pages
11 – 50 pages	$0.70/per page
51+ pages	$0.28/per page

• For a third party:	$20.68 (not related to continuing care) plus
1 – 10 pages	$1.36 per page for the first ten pages
11 – 50 pages	$0.70/per page
51+ pages	$0.28/per page
Actual Cost of Postage	

Request Fulfilled on: _____by:_____

Date Staff member initials