Health Insurance Portability and Accountability Act (HIPAA) // MeMD
7332 E. Butherus, Suite 104
Scottsdale, AZ 85260
hipaacompliance@memd.me
Phone: 1-855-636-3669 // Fax: 480-247-6482

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Date of request: _____

Patient Name: _____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: _____ **Email:**_____

I allow MeMD to share: (CHECK ALL THAT APPLY):

☐ All of my health information

☐ My health information regarding treatment for alcohol and/or substance abuse (requires specific authorization)

☐ My health information regarding psychiatric or mental health care (requires specific authorization)

☐ My health information regarding HIV and/or AIDS (requires specific authorization)

☐ Other (please specify): _____

I authorize **MeMD** to send my protected health information to:

Name/Entity: _____

Address: _____

Email: _____

Phone: _____

Fax: _____

Please specify if you would the information to be sent as a **paper** or **electronic** copy: _____

Health Insurance Portability and Accountability Act (HIPAA) // MeMD
7332 E. Butherus, Suite 104
Scottsdale, AZ 85260
hipaacompliance@memd.me
Phone: 1-855-636-3669 // Fax: 480-247-6482

Expiration of Authorization

This authorization expires: _____

If no date is given, authorization will expire one year from the date signed.

I understand that:

- By signing this form, I authorize the use or disclosure of my protected health information as indicated above.
- I may refuse to sign this authorization, this is strictly voluntary, and my refusal to sign this authorization will not affect my treatment or payment for health care.
- Information disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy regulations. MeMD shall not be held liable for any consequences resulting from re-disclosure.
- MeMD may charge an administrative fee to cover the cost of labor, copying, and postage. MeMD will inform me of any charges and arrange for payment prior to releasing my information.
- I may change or revoke this authorization for disclosure at any time by sending a request to the MeMD HIPAA Compliance Officer.

_____ _____

Patient/Representative Signature **Date**

If signed by someone other than the patient, please indicate relationship to patient: _____

If not already provided, MeMD will require verification of the authority of the representative to act on behalf of the patient before this request is considered as complete.

REVOCATION OF AUTHORIZATION

I NO LONGER WANT MEMD TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE PERSON OR ENTITY INDICATED ABOVE.

Patient Name: _____

Patient Signature: _____

Date of Revocation: _____