

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

TO: _____

I, the undersigned authorize the above physician/clinic/hospital to release my (or give relationship) _____ medical record. This authorization includes the release of information related to HIV/AIDS or genetic testing, AIDS Related Complex and/or tests for antibodies to the AIDS/HIV virus as well as any related conditions. The purpose of this request is to provide continuity of medical care.

I authorize you to release the following:

- () Entire medical record
- () Medical records from the following dates: _____ to _____
- () Medical records regarding the following condition(s): _____

() Other Specify: _____

This information is to be forwarded to the office of:

Jennifer L. Thie, M.D. LLC
4430 Carver Woods Dr., Ste. 125
Cincinnati, OH 45242
Phone: 513.794.1430
Fax: 513.792.6849

I understand that if the person or entity that receives my personal health information is not the party to whom it was intended, then the information described previously may be re-disclosed and no longer be protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may revoke this authorization in writing at any time by completing a signed and dated revocation notice to be received by the office of Dr. Jennifer Thie. This authorization expires sixty days from today's date.

Patient Name

Date

Signature of Patient or Legal Guardian

_____/_____/_____
Birthdate

Name of Legal Guardian

Relationship to Patient