

**Alpha-Omega Direct Primary Care, LLC and
Tatiana Hamawi, M.D. dba Alpha-Omega Medical Care
111 Elm Street, Suite 201, Worcester, MA 01609-1967
Tel: 508-753-7700 Fax: 508-753-7737**

HIPAA Authorization for the Disclosure of Protected Health Information to this Practice.

Name: _____ DOB: _____

I hereby authorize the release of the above named individual's health information to the above entities from the following health provider:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____ Fax: _____

Information to be released:

___ entire medical record for the period: From: _____ To: _____

OR choose among the following:

- ___ medications and allergy list
- ___ immunization records
- ___ office visit(s) dated: _____
- ___ information as requested on form (e.g. school, camp, employment, disability form(s))
- ___ test results (list types of tests and dates): _____
- ___ consultation reports from (list doctors' names and dates): _____
- ___ other (please describe): _____

Your protected health information may include general information related to your psychiatric health, drug/alcohol abuse, communicable diseases, abortion, or other information you may consider sensitive.

The information in your health record will not include sensitive information relating acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) unless you initial here. **Initial here to include HIV/AIDS-related information:** _____.

The purpose of the release of this information is for:

- ___ changing to a new PCP
- ___ other (please describe): _____

Indicate date or event that will cause this authorization to expire: _____

(If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.)

I understand that:

- 1) I have a right to revoke this authorization at any time. And that if I revoke this authorization, I must do so in writing to Dr. Tatiana Hamawi, M.D. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- 2) If the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information disclosed as permitted above could be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. I release Alpha-Omega Medical Care and Dr. Tatiana Hamawi, M.D. from any legal liability that may arise from the disclosure or re-disclosure of this information.
- 3) Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, unless the authorization is necessary for creating the protected health information for disclosure to a third party (e.g. physical exams for school, camp, and insurance purposes).
- 4) There may be a fee for photocopying my health information.

I have read and understand the above statements and authorize the disclosure of the information as requested above.

Signature of patient or legal representative

Printed Name

Date