DRAGONFLY
HEALTH

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Turnersville, NJ 08012
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Email: records@dragonflyhc.com

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize: Dragonfly Health

Purpose of disclosure: ☐ Proof of condition ☐ Continuing Care ☐ Specialist for condition.

Condition of interest: _____

Information to be release: Date of last visit/s to office within 6 months of document.

☐ Discharge Summary ☐ Last Exam/Notes ☐ Progress Notes/Provider Notes

☐ Counselor/Therapist Summary ☐ Orders ☐ X-Ray Reports ☐ X-Ray Films/MRI

☐ Lab Reports/Pathology ☐ Procedure Reports ☐ Diagnostic Test Reports

☐ Consultation Report

PHYSICIAN AND OR PRACTICE NAME: _____

FAX#: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

I understand the expiration date of this authorization is one year. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulation. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care. I understand that my medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse. Psychotherapy notes will not be released per facility policy and HIPAA privacy rules, 45 CFR Parts 160 and 164, 164.502

_____ _____ _____ _____#

(Signature of Patient or personal representative) Relationship Date Phone