

Authorization for Release of Protected Health Information (PHI)

Records Released From:

Records Received By:

Practice/Physician

Practice/Physician

Address, City, St and Zip

Address, City, St and Zip

Phone and Fax Numbers

Phone and Fax Numbers

Patient Information:

Patient Name

DOB

Social Security Number (optional)

Address

City

St

Zip

Primary Phone

Secondary Phone

This authorization will expire on the following: (Fill in the Date or the Event but not both)

Date

Event

Unless shorter time period is specified, this authorization will expire in 180 days after it is signed

Purpose of disclosure:

Is this request for psychotherapy notes? If yes, then this is the only item you may request on this authorization. You must submit a separate form for additional items. If no, then you may check as many items below as you need.

Description

Date

Description

Date

Description

Date

All PHI in Record

Operative Reports

Radiology Reports

Lab Reports

Pathology Reports

ER Records

Medication List

Other

Other

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (initial) If not applicable, check here.

If this authorization is for disclosure of genetic information, please describe: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may request a copy of this form after I sign it.

If the request of PHI is for the purpose of marketing will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information: Yes No If yes, please describe: _____

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature

Printed Name

Date

Legal Representative/Guardian Signature

Printed Name

Date