

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

<b>Section 1 - Patient Information</b>				
Patient's Legal Name	Date of Birth	Telephone Number		
Street Address:	City, State, Zip Code			
<b>Section 2 - Information to Be Released:</b> I authorize the use and disclosure of the protected health information ("PHI") about me that is indicated in the checklist below. I understand that such uses and disclosures may only be made by, and only to, the persons or organizations identified in Section 4.				
Approximate Dates of Treatment ( <b>Must Be Completed</b> ): <small>(Example: 01/01/2022 - Present)</small>				
Specific Information to be Disclosed				
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Entire Medical Records  <input type="checkbox"/> Abstract of Health Information  <input type="checkbox"/> Progress Notes  <input type="checkbox"/> Office Visit Notes  <input type="checkbox"/> ER Notes  <input type="checkbox"/> Discharge Summary  <input type="checkbox"/> History &amp; Physical  <input type="checkbox"/> Immunizations  <input type="checkbox"/> Other (Specify): _____                  _____             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Radiology &amp; Cardiology Report  <input type="checkbox"/> Radiology &amp; Cardiology CD/Films  <input type="checkbox"/> EKG  <input type="checkbox"/> Lab Results  <input type="checkbox"/> Operative/Procedure Report  <input type="checkbox"/> Physical/Occupational/Speech Therapy  <input type="checkbox"/> Medication List  <input type="checkbox"/> Billing Records             </td> </tr> </table>			<input type="checkbox"/> Entire Medical Records <input type="checkbox"/> Abstract of Health Information <input type="checkbox"/> Progress Notes <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> ER Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Immunizations <input type="checkbox"/> Other (Specify): _____ _____	<input type="checkbox"/> Radiology & Cardiology Report <input type="checkbox"/> Radiology & Cardiology CD/Films <input type="checkbox"/> EKG <input type="checkbox"/> Lab Results <input type="checkbox"/> Operative/Procedure Report <input type="checkbox"/> Physical/Occupational/Speech Therapy <input type="checkbox"/> Medication List <input type="checkbox"/> Billing Records
<input type="checkbox"/> Entire Medical Records <input type="checkbox"/> Abstract of Health Information <input type="checkbox"/> Progress Notes <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> ER Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Immunizations <input type="checkbox"/> Other (Specify): _____ _____	<input type="checkbox"/> Radiology & Cardiology Report <input type="checkbox"/> Radiology & Cardiology CD/Films <input type="checkbox"/> EKG <input type="checkbox"/> Lab Results <input type="checkbox"/> Operative/Procedure Report <input type="checkbox"/> Physical/Occupational/Speech Therapy <input type="checkbox"/> Medication List <input type="checkbox"/> Billing Records			
<b>Section 3: Authorized to Release (FROM):</b> I authorize the release of my PHI from the entity identified below.				
Facility Name	Telephone Number	Fax Number		
Street Address:	City, State, Zip Code			
<b>Section 4: Authorized to receive (TO):</b> I authorize the release of my PHI to the entity identified below.				
Name and Relationship / Facility and Department	Telephone Number	Fax Number		
Street Address:	City, State, Zip Code			
<b>Section 5: Purpose of the Use or Disclosure:</b>				
<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Disability				
<b>Section 6 Method of Disclosure:</b>				
<input type="checkbox"/> U.S Mail <input type="checkbox"/> Fax <input type="checkbox"/> CD/DVD <input type="checkbox"/> Pick Up with Photo ID				
<p><b>I understand that:</b></p> <p><b>1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.</b></p> <p><b>2. This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.</b></p> <p><b>3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.</b></p> <p><b>4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.</b></p> <p><b>5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.</b></p> <p><b>6. My signed (written) authorization will expire in ninety (90) days unless I provide an alternate expiration date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.</b></p>				
<b>I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE:</b>				
Patient/ Legal Representative Signature:		Date:		
Printed Name:	Description of Legal Representation:			