Authorization for Release of Patient Health Information

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PLEASE PRINT OR TYPE:

Patient Name: _____ Birth Date: _____

Address: _____ Social Security #: _____

_____

Phone: _____

I authorize _____, to release the patient health information of the named patient above
Name of Facility or Person

to: _____
Name & Address of person or organization to which disclosure is to be made

Phone:_____ Fax:_____

I understand that this information will include, where applicable, test results about HIV/AIDS, alcohol, or drug abuse. I understand that this information may be sent by telephone, facsimile, or electronic means and that reasonable efforts will be made to protect confidentiality.

☐ Yes, I consent to the release of this information. ☐ No, I do not consent to the release of this information.

Description of information to be released: **SPECIFY TREATMENT DATES: _____to_____**
(CHECK ALL THAT APPLY)

☐ Pertinent Information	☐ Phone Notes	☐ Therapy Reports	☐ Other: _____
☐ Discharge Summary	☐ Email Correspondence	☐ Radiology Reports	_____
☐ History & Physical	☐ Progress Notes	☐ Billing Records	_____
☐ Consultation Reports	☐ Laboratory Reports (including HIV/AIDS)	☐ Entire Medical Record	_____

This information is being released for the purpose of (*CHECK ALL THAT APPLY*)

☐ Continuing Care	☐ Legal	☐ Other:_____
☐ Reimbursement	☐ Personal, for own purposes (*requested by patient)*	_____

Expiration Date or Event: I understand that failure to provide an expiration date or event in the space provided below will result in this authorization expiring 180 days from the date that it is signed.

Expiration Date or Event: _____

☐ I understand that I may revoke this Authorization at any time. Revocation does not affect information released prior to the date of revocation. To revoke this Authorization, please send written notice to the organization named above.

☐ I understand that my treatment and the payment for my health care will not be affected if I do not sign this form.

☐ I understand that I may inspect and copy the information described on this form upon request.

☐ I understand that I will receive a copy of this form after I sign it.

☐ I understand that the above named organizations are relieved of responsibility or liability for release of the information, once the information has been released to the designated recipients.

_____ _____ _____
Signature of patient or legal representative | Authority or Relationship to Patient (If Applicable) | Date

_____ _____ _____
Signature of Witness | Witness Name | Date

FOR STAFF USE ONLY:

Will direct or indirect compensation, of any kind, be received for using or disclosing the health information described above? ☐ Yes ☐ No

☐ Inspection ☐ Copying Payment amount rec'd $_____ Payment received from: _____

Request for inspect or copy: ☐ Accepted ☐ Denied Date:_____ Comments: _____