AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST		DOB
ADDRESS	SSN	
CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	ENTITY RECEIVING THE PHI:		
	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	ATTENTION:		

This authorization will expire on the following date or event. If date or event are not indicated, authorization will expire within 12 months from date signed.

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
☑ All PHI in the record		
☐ Progress Notes		
☐ Laboratory Tests		
☐ X-Ray Tests / Reports		
☐ History and Physical Examination		
☐ Discharge Summary		
☐ Consultation Reports		
☐ Itemized Billing Statement		
☐ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

☐ AIDS or HIV test results ☐ Psychiatric or mental care / treatment

☐ Alcohol, drug or substance abuse treatment ☐ Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND 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 TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER 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 DISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:
Signature of Representative (if necesary):	Date:
Personal Representative's Relationship to Patient:	