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Patient Authorization to Release Protected Health Information (PHI)

Patient Name: ____ DOB: _____________

Home Phone: __________________________ Mobile phone: ________________________

Address: ____
(Street address)
____
(City, State, Zip code)

I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY HEALTH INFORMATION:

FROM: Name: ____

Address: ____

Phone #: ______________________________ Fax #: ____________________________

TO BE RELEASED TO:

Name: ____

Address: ____

Phone #: ______________________________ Fax #: _________________________________

DATES OF RECORDS: FROM: _____/______/______ **TO**: ______/______/____________

TYPES OF RECORD(S) TO BE RELEASED: *(CHECK AS APPROPRIATE)*

______ *Hospital and ER records* _______ *Lab results* ______*Immunization record*
______ *Office Progress Reports* _______ *Pathology results* ______*Operative reports*
______ *Consultation Reports* _______*Diagnostic Tests* _____ *Procedure reports*
______ *Entire Medical Record for time period above*
______ *Other (please specify* ____

If the records include information from another health care provider or entity,

_________ *I consent*
_________ *I do not consent*
to have these records released under this Authorization

My initials below authorize inclusion of the following types of sensitive information:

Drug/Alcohol treatment ___________
HIV/AIDS ___________
Mental Health ___________

PHI will be released to provider/entity via agreed upon method (fax, mail, email, verbal communication)

PURPOSE OF AUTHORIZATION

The authorization is for the following purpose: *(Check as appropriate)*

_________*Personal Use* _______ *Insurance* _______ *Legal*
_________ *Patient Care* _______ *Employment* _______ *New Physician/Practice*
_________ *Other:* ____

EXPIRATION OF AUTHORIZATION: This authorization will expire one year from the date it is signed.

Patient Acknowledgement

I understand:

- *This authorization is voluntary*
- *My treatment, payment for it and/or eligibility for enrollment of benefits cannot be*
- *conditioned on my signing this authorization form*
- *I have the right to inspect or copy my PHI to be used or disclosed pursuant to this*
- *Authorization, as permitted by law*
- *That once information covered by this Authorization has been disclosed, redisclosure of the information by that recipient is possible and the information may no longer be protected.*
- *This Authorization to disclose PHI may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. Revocation of Authorization must be made in writing directed to the attention of the entity releasing the PHI.*
- *My treatment, enrollment in a health plan or eligibility for benefits cannot be conditioned on my signing this Authorization form.*

____ _____________________
Patient or Personal Representative Signature *Date*

____
Printed Name