

**Authorization to Release Protected Health Information**

Date: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Information to be released from:

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip : \_\_\_\_\_

This information may be given to and used by the following individual or organization:

Information to be used for the purpose of:

Request by patient     Treatment of patient     Other: \_\_\_\_\_

I hereby request and authorize you to release information

to: \_\_\_\_\_

Disclosure Method:  Pickup     Mail     Fax#: \_\_\_\_\_

Other: \_\_\_\_\_

I authorize the user or disclosure of the above named individual's health information as described below.

Information to be released:

All records of treatment from \_\_\_\_\_ to \_\_\_\_\_.

Entire record (complete)     Physician's Order's     Other: \_\_\_\_\_

History & Physical Report     Progress Notes    \_\_\_\_\_

Consultation Report     Lab Results    \_\_\_\_\_

Operative Report     HIV Results    \_\_\_\_\_

Immunization Record     X-Ray Reports

- I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental services, and treatment for substance abuse.
- I understand there will be a fee for copying records
- I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulation, the information obtained may be re-disclosed and no longer protected by these regulations.
- Unless otherwise revoked, this authorization shall expire on the date, event, or condition: \_\_\_\_\_ . If I fail to specify an expiration date, event, or condition, this authorization with expire in 6 months.
- I understand that I may revoke this authorization at any time in writing by contact the Privacy Officer at \_\_\_\_\_ .
- I understand that this revocation does not apply to information that has already been release in response to this authorization.  
Failure to sign this authorization  
 Will have no adverse impact on the deliver of care or reimbursement of patient charges  
 Will have the following adverse impact:

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by a Legal Representative, Please  
state relationship to Patient

\_\_\_\_\_  
Witness

