

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Date Of Birth: _____ Day Phone #: _____

I authorize release of my records TO: _____
FROM: _____

For the following reason: Personal Continued care with another physician Legal Other: _____
Date Needed by: _____

Type of information to be disclosed: Date(s) of Treatment: _____ Body Part: _____
 Chart Notes X-ray Disc Operative Report Radiology Report All Records Other: _____

****The following items must be initialed to be included in the use or disclosure of other health information****

- HIV/AIDS related health information and/or records.
- Mental health information and/or records.
- Genetic testing information and/or records.
- Drug/Alcohol diagnosis, treatment and/or referral information. (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

I request my records be provided in the following format: Paper copy Electronic Copy

- Please call me when records are ready to pick up at this number: _____
- Please mail my records to this address: _____
- Please fax my records to this number: _____
- Please email my records to this address: _____

I understand this authorization with expire on: _____ (If not specified, authorization will expire one year from date signed.)

I understand that:

- Authorizing the disclosure of this information is voluntary. My right to treatment, payment, enrollment, or eligibility for benefits is not contingent on signing this form.
- I have the right to revoke this authorization at any time by submitting a written request to the address provided at the top of this form. I understand that this will not apply to information that has already been released as a result of this authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the person or facility listed above as receiving this information is not covered by federal health privacy regulations, the released information may be re-disclosed and may no longer be protected by federal or state law.

Signature of Patient or Patient's Legal Representative _____ Date _____

ID Verification: Document and Number _____

For administrative use only: Chart Number: _____
Records processed by Employee Initial and Date: _____
Records: _____ Faxed _____ Mailed _____ Emailed _____ Picked up _____
(If picked up, Employee Initials and Date _____)

Provider Review: