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AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION (PHI)

Read & Complete Entire Document Before Signing

Patient Name: _____ Maiden/Previous Name: _____
Date of Birth: _____ Medical Record # (if known) : _____Phone #: _____
Address: _____
(Street) *(City)* *(State)* *(Zip)*

I authorize the use or disclosure of the above named individual's PHI as described below **(Office Sending Records):**

Name, address and phone number of health provider or entity to release this information:
Name:_____Phone number:_____
Address:_____Fax number:_____
City:_____State:_____Zip code:_____

Description of information to be used or disclosed:
Medical Records From: _____ To: _____
Other: (Please specify records and dates): _____
_____

Name, Address and Phone Number of person(s) or organization to whom this information will be **sent to**:
Name:_____Phone number:_____
Address:_____Fax number:_____
City:_____State:_____Zip code:_____

This protected Health Information is being used or disclosed for the following purpose:
_____ My personal records _____ For legal purposes, Attorney _____
_____ For other Healthcare providers _____ Other (please describe) _____

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary. My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
- I may revoke this authorization, in writing, at any time by sending such written notice to Health Care Provider specified above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- Once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.

This authorization will remain in effect unless you specify a date or event at which time this authorization expires:
Expiration Date or Event: _____ _____

This authorization may include disclosure of the following information only if I place my initials on the appropriate line item below:
_____ HIV related information
_____ mental health treatment
_____ drug, alcohol, or substance abuse or treatment

If I authorize the release of HIV—related, alcohol or drug substance abuse or treatment, or mental health treatment information the recipient is ***PROHIBITED FROM REDISCLOSING SUCH INFORMATION*** without my authorization unless permitted to do so under federal or state law.

We will provide your PHI in hardcopy format (fax or hardcopy) unless you specifically request otherwise. If you have records in our electronic health record, you may request an electronic copy of those records and you may request we send an electronic copy of those records to a third party. We will charge you the cost of the electronic media you specify and will report the fee to you upon receipt of your request. Please specify: _____

All items on this form have been completed and my questions about this form have been answered & I have been provided a copy of the form.

Signature of Patient/Guardian: _____ Date: _____
Photo ID required for records to be picked up. Relationship to Patient:
Witness to ID: _____ _____