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Authorization to use/or Disclose Protected Health Information (PHI)

Patients Name: ______________________________
Date of Birth: ______________ Phone: ______________
Address: ______________________________
City: ______________ State: ________ Zip: ________

I AUTHORIZE the information to be disclosed by:
Name & Address of Party you are **REQUESTING PROTECTED HEALTH INFORMATION (PHI) FROM:**
Name: ______________________________
Address: ______________________________
Phone Number: ______________ Fax Number: ______________

I AUTHORIZE the information to be disclosed to:
Name and Address of Party you want **PROTECTED HEALTH INFORMATION (PHI) RELEASED TO:**
Name: ______________________________
Address: ______________________________
Phone Number: ______________ Fax Number: ______________

INFORMATION TO BE RELEASED

☐ Entire medical record (PHI)

☐ Specify ______________________________

PURPOSE OF DISCLOSURE

☐ Physician / Second Opinion ☐ Attorney / Litigation ☐ Insurance Request ☐ Moving / Relocation

☐ Other ______________________________

The following information is important for you to read:
This authorization is effective until ______________ (if no date is entered the authorization will be valid for 1 year from date of signature and includes all records.

- I understand that the information to be disclosed may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STD's, HIV test results, developmental disabilities, and genetic testing results.
- I understand that I have a right to revoke this authorization at any time; I must do so in writing and present my written revocation. I understand that the revocation will not apply to information that has already been released. I understand that I have a right to inspect and/or receive a copy of the health information to be released and I may be charged a fee for any copies of the medical records that I receive.
- I understand that, if the person or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered heath care providers or health care clearing houses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law.
- I understand that I will be charged for any copies of the medical records.
- A photocopy of this authorization shall be considered as valid as the original.

______________________________ ______________
Signature of Patient / Legal Representative: Date

______________________________ ______________
Print Name: Relationship:

Internal Use: Information released by: ______________________________

Updated on 08/01/2010