

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____ **SSN# (Optional):** _____

<u>INFORMATION REQUESTED FROM:</u>	<u>REQUESTOR OF INFORMATION:</u>
Name: _____	<input type="checkbox"/> Self <input type="checkbox"/> Other: _____
Address: _____ _____	Address: _____ _____
Phone #: _____	Phone #: _____

INFORMATION TO BE DISCLOSED *(please specify):*

Description	Date(s)	Description	Date(s)	Description	Date(s)
<input type="checkbox"/> Admission Form		<input type="checkbox"/> Operative Documentation		Super-Confidential Information	
<input type="checkbox"/> Physician Dictated Reports		<input type="checkbox"/> Invasive Procedure Documentation		<input type="checkbox"/> HIV Testing	
<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Medication Sheets		<input type="checkbox"/> HIV & AIDS Documentation	
<input type="checkbox"/> Physician Progress Notes		<input type="checkbox"/> Nursing Documentation		<input type="checkbox"/> Psychiatric Documentation	
<input type="checkbox"/> ER Documentation		<input type="checkbox"/> Other: _____		<input type="checkbox"/> Alcohol & Drug Abuse Documentation	
<input type="checkbox"/> X-ray Reports		<input type="checkbox"/> Entire Medical Record		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Laboratory Reports					
<input type="checkbox"/> EKG(s)					

PURPOSE OF DISCLOSURE *(please specify):*

Continuing care with another physician or hospital
 Personal Copy
 Other (please specify): _____

AUTHORIZATION:

I understand that:

1. This authorization will remain in effect for 30 days.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient/Guardian/
 Representative Signature: _____

Date: _____

Patient/Guardian/
 Representative Printed Name: _____

Relationship
 to Patient: _____

Witness Signature: _____

Date: _____