Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Legal Name	Birthdate	Social Security No. *(optional)*
Address		
City	State	Zip Code

INFORMATION TO BE RELEASED TO (Requestor)

Name	
Address	
City State Zip	

Facility (Covered Entity Provider) **authorized to release PHI**

Name	
Address	
City	State Zip

This authorization shall expire on the following date or event: _____ . If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.

Purpose of disclosure:

❑Medical Care ❑Legal ❑Insurance ❑Personal ❑Other _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED Starting _____ Ending _____

	Starting Date	Ending Date		Starting Date	Ending Date
❑ All PHI in the medical records			❑ Consultation Reports		
❑ History and Physical Reports			❑ Discharge Summary		
❑ Progress Notes			❑ Itemized Billing Statement		
❑ X-Ray Tests/Reports			❑ Patient Information Form		
❑ Laboratory Reports			❑ Other Specified:		

The Protected Health Information listed below WILL BE released when included in the above medical information unless specifically indicted otherwise.

Psychiatric/Mental Information
Alcohol/Drug/Substance Abuse Information
AIDS/HIV/Genetic Information
OTHER _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization.
4. If the requester 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 redisclosed.
5. 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.

I have read the above and authorized the disclosure of the protected health information as stated:

(1) Patient Signature_____ Date:

(1) PATIENT REPRESENTATIVE SIGNATURE (IF APPLICABLE)	(2) RELATIONSHIP TO PATIENT Date: