Authorization to Release Protected Health Information (PHI)

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| **Name (*First, Middle, Last)* PLEASE PRINT** | **Birth Date (*Month DD, YYYY)*** |

| **PROVIDER AUTHORIZED TO RELEASE THE PHI:** | **ENTITY RECEIVING THE PHI:** |
|---|---|
| NAME: | NAME: |
| ADDRESS: | ADDRESS: |
| CITY: STATE: ZIP: | CITY: STATE: ZIP: |
| FAX #: | FAX #: |

Purpose of this Disclosure: ○ Medical ○ Legal ○ Personal ○ Insurance ○ Other

**PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE**

| **Description** | **Start Date** | **End Date** |
|---|---|---|
| o All PHI in the record | | |
| o Progress Notes | | |
| ○ Laboratory Tests | | |
| ○ X-ray Tests/Reports | | |
| ○ History & Physical Exam. | | |
| ○ Discharge Summary | | |
| ○ Consultation reports | | |
| ○ Itemized Billing Statement | | |
| ○ Other: | | |

**The following information will be released when included in the above information unless you indicate otherwise:**

○ AIDS or HIV test results ○ Psychiatric or mental care / treatment ○ Alcohol, drug or substance abuse treatment

**I UNDERSTAND THAT:**

1. I may refuse the sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign.

| | |
|---|---|
| **SIGNATURE OF PATIENT:** | **DATE:** |
| **SIGNATURE OF PATIENTS REPRESENTATIVE (IF NECESSARY):** | **DATE:** |
| **WITNESS:** | **DATE:** |

**This authorization will expire 12 months after date of signature if no specific date is given. Expire Date: _______**