Authorization to Release Protected Health Information (PHI)

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( )

_____

LAST NAME FIRST NAME MIDDLE MAIDEN/OTHER TELEPHONE

_____ / / _____

ADDRESS CITY STATE ZIP DATE OF BIRTH

I authorize and give my permission for:

_____
Organization/Individual

_____
Street Address

_____
City State Zip

_____
Phone FAX

To release information to:

_____
Organization/Individual

_____
Street Address

_____
City State Zip

_____
Phone FAX

Information to be released: **

	Date of Service		Date of Service
❑Lab Reports	_____	❑Immunization Records	_____
❑X-ray Written Reports	_____	❑Workman's Comp Records	_____
❑Progress Notes	_____	❑ Other	_____

❑ALL including allergy skin testing and allergy extract formulas _____

The disclosure is being made for the following purpose(s): **

❑Further Medical Care	❑Physician Dissatisfaction	❑Relocation/Moving
❑Staff Dissatisfaction	❑Attorney/ Court Case	❑Workman's Comp
❑Personal Use	❑Insurance / Billing Difficulties	❑Other (comments) _____
❑Changing Physicians (explain)	❑Insurance Change (specify name or	_____
_____	New Company) _____	_____

I understand that if the person(s) and/or organizations listed above are not health care providers, health plans, or health care clearing houses, who must follow the federal privacy standards, the health information disclosed is a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

I understand that a copy shall be considered as valid as the original. I may inspect and arrange for copies of the information that is to be disclosed with the Health Information Management department. I understand that I have a right to revoke this authorization at any time by providing written notice to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company as needed to contest a claim under my policy.

I understand that authorizing this disclosure of this medical information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits with the organizations/persons listed above. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I fully understand that my PHI relating to the above records being released may include reference to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, and/or HIV test results/acquired immune deficiency syndrome.

Unless otherwise revoked, this authorization will **expire 60 days from the date signed**.

****Records will be available 3 business days after requested. ****
****Rush fee of $25.00 will be assessed if needed sooner. ****

_____ _____ _____
Signature of Patient or Legal Representative (If Legal Rep., state relationship to patient) Date Signed Time Signed

_____ _____ _____
Signature of Witness (only required when patient cannot sign) Date Signed Time Signed

Office Use Only

Date Needed By: _____ Records to be: ❑Mailed ❑Faxed ❑Picked Up Date Completed: _____
Info Released By: _____ Time Picked Up: _____ Verified ❑ SSN ❑Other ID-Photo
❑ Drivers License #

Updated 3/14