

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete One Form Per Patient

PATIENT INFORMATION:

 Name

 Street Address City, State, Zip Code

 Email Address

RELEASE MEDICAL RECORDS FROM:

 Name

 Phone Number

 Street Address

 Email Address / Fax Number

 Date of Birth

 Social Security

 Phone Number

RELEASE MEDICAL RECORD TO:

 Name

 Phone Number

 Street Address

 Email Address / Fax Number

DATES OF SERVICE: (REQUIRED) ____/____/____ to ____/____/____

MEDICAL RECORDS TO BE RELEASED: (REQUIRED)

___Office Visits ___Radiology Reports ___ Pathology Reports

___Laboratory Reports ___ Discharge Summary ___Other _____

PURPOSE OF RELEASE: (REQUIRED)

___Transfer of Care to a New Provider - You must notify your Insurance Carrier of the Change in Provider (INITIALS): _____

___Personal ___Referral to Specialist ___Disability Determination ___Insurance ___Legal Investigation

___Other (please specify) _____

(REQUIRED) ___ I DO ___ I DO NOT authorize the release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse (INITIALS): _____

SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER):

I acknowledge I am a legal representative, or an authorized person of the patient listed above. By signing below, I am authorizing the release and disclosure of the patient's protected health information. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request with written notification, and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

 Signature of Legal Representative/Patient 18yrs or older

 Printed Name of Legal Representative/Patient 18 yrs or older

 Date

 Relationship to Patient