Authorization for Release of Medical Records

Patient's Identification:

Patient's Name:_____ Date of Birth: _____

Other Name(s) Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Last 4 Digits of Social Security #:_____ Phone Number: _____

Who is Authorized to Release PHI ("Provider"):

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

Who is Authorized to Receive PHI:

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

I request that PHI be provided in the following format *(if readily reproducible in this format):*

☐ Paper Copy ☐ Fax

Purpose of Request *(must check one):*

☐ At the Request of the Patient ☐ Attorney/Legal ☐ Billing/Payment ☐ Treatment or Consultation

☐ Other, (specify):_____

Description of PHI to be Released *(check all that apply):*

☐ Complete Medical Records	☐ Consultation(s)	☐ Operative Report(s)	☐ Physician Order(s)
☐ History/Physical Exams	☐ Diagnostic Testing Reports(s)	☐ Patient Allergies	☐ Progress Note(s)
☐ Lab Test Result(s)	☐ EKG/Cardiology/Report(s)	☐ Pathology Report(s)	☐ Radiology Reports/Images
☐ Emergency Record(s)	☐ Itemized Billing Statement(s)	☐ Patient Medication(s)	☐ Treatment Plan(s)
☐ Discharge Summary	☐ Nurses Notes	☐ Clinic Records	☐ Therapy Records
☐ Abstract	☐ Other (specify):_____		

NOTE: *This form MAY NOT BE used to release Psychotherapy Notes*

If the PHI release of which is authorized contains information about drug/alcohol abuse, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment or any other sensitive information, by signing this Authorization, I confirm that I authorize its release unless I otherwise state here:

_____

Dates of Service for PHI to be Released *(must check one):*

☐ Any and all* ☐ From *(date)*: _____ To *(date)*: _____

**** Indicating "any and all" records to be released will include all records through the date the patient or patient representative signs this Authorization as long as the Authorization is not expired or revoked.***

Signature REQUIRED ***on back side.***

Right to Revoke: I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to Provider's address listed above, Attention - Health Information Management Department, and that the revocation will be effective upon receipt of this notice by Provider except to the extent that action has already been taken in reliance on this Authorization.

Expiration Date or Event: This Authorization will expire 12 months from the date of my signature below unless I revoke this Authorization or unless I otherwise specified here: _____

Re-Disclosure: I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.

Signing This Authorization is Voluntary: I understand that I do not have to sign this Authorization and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing the Authorization.

Signature of Patient or Personal Representative: By signing this Authorization, I authorize disclosure of protected health information of above named patient by Provider as described above in this Authorization.

_____ _____ _____

Signature of Patient or Personal Representative *Date* *Time*

If this Authorization is signed by the patient's personal representative: Please specify below the personal representative's printed name, indicate personal representative's authority to act on behalf of the patient and attach supporting documentation:

_____

Personal Representative's Printed Name/Authority to Act on Behalf of Above Named Patient

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OFFICE USE ONLY

Verified by:_____

Identity of Requestor Verified via:

☐ Photo ID ☐ Matching Signature ☐ Other, specify: _____

Documentation supporting personal representative's authority to act on behalf of the patient is attached:

☐ Yes ☐ No ☐ Not Applicable

Document Type Validated: _____