

**AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION (PHI)  
Please Print or Type all information except signatures and initials**

Patient Name:	Birthdate:	Social Security No.:
Address:	Home Phone: ( ) -	Work Phone: ( ) -

I hereby authorize \_\_\_\_\_, to disclose records obtained in the course of my evaluations and/or treatment to:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Type of Access Requested: \_\_\_\_\_ Copies of Records \_\_\_\_\_ Inspection of Records  
Medical Records: (Entire Record or Selected Portions of PHI as marked)

Description:	Dates	Description:	Dates	Description:	Dates
<input type="checkbox"/> <b>ENTIRE RECORD</b> (or Portions):		<input type="checkbox"/> Laboratory Results		<input type="checkbox"/> Face Sheet	
<input type="checkbox"/> Discharge Summary		<input type="checkbox"/> Imaging/Radiology		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Emergency Room		<input type="checkbox"/> Nursing Notes		_____	
<input type="checkbox"/> History & Physical		<input type="checkbox"/> Medication Records		_____	
<input type="checkbox"/> Consultation Reports		<input type="checkbox"/> Psychological Records		<input type="checkbox"/> <b>BILLING RECORDS</b>	
<input type="checkbox"/> Operative Reports		<input type="checkbox"/> Psychiatric Records		<input type="checkbox"/> Itemized Bills	
<input type="checkbox"/> Rehab. Services		<input type="checkbox"/> Progress Notes		<input type="checkbox"/> UB92	
Type: _____		<input type="checkbox"/> Physicians Orders			
		<input type="checkbox"/> Physician Prog. Notes			

\_\_\_\_\_ (Initials) IDO  or IDO NOT  consent to release of information relating to psychiatric or physiological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information: \_\_\_\_\_

List ALL of the purposes for the release or disclosure of Protected Health Information:

- Continuation of Medical Care with another health provider       Attorney: \_\_\_\_\_  
 Insurance Claim      Address: \_\_\_\_\_  
 Personal Use       Other: \_\_\_\_\_

*This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the facility's Health Information department for Medical records, or contact the Business Office Manager for Billing Records.*

This consent shall become invalid and expire 180 days from the date of signature: Expiration Date: \_\_\_\_\_ or  
Expiration Event: \_\_\_\_\_ or None: \_\_\_\_\_ or define: \_\_\_\_\_

I understand that:

- Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. such re-disclosure will no longer be protected by this authorization.
- I have the right to receive a copy of this authorization. Copy of the authorization received.  \_\_\_\_\_ Initials
- A copy or facsimile (fax) of this authorization is as valid as the original.
- My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.

I hereby release \_\_\_\_\_ and it's agents from any and all legal liability and injuries that arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. Mail service and/or electronic facsimile and/or delivered to employees or duly authorized agents of the recipient.

**I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.**

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Signature of Patient/Legal Guardian or Representative\*)  
If signed by other than patient, indicate relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ DATE: \_\_\_\_\_

*\*Authorized representative must submit copies of legal documents supporting his or her authority to act on the patient's behalf.*

**To the Party Receiving this information:** This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.

**FACILITY USE ONLY:**

Complete by: \_\_\_\_\_ Date Completed: \_\_\_\_\_  
Medical Record #: \_\_\_\_\_ Business Account #: \_\_\_\_\_