Authorization for the Release of Protected Health Information

Patient Name: ____ Date of Birth: ____________________
Address (including City/State/Zip)____
____
Phone Number: ________________________________ Email ____________________@______________

Release Information From:	**Release Information To:**
Provider/Facility Name: ___________________________	____
____	____
Address: ______________________________	Address: ______________________________
City/State/Zip: __________________________	City/State/Zip: __________________________
Phone: _______________ Fax _____________	Phone: _______________ Fax _____________

Information to be Released: **Service Dates:** From: ________________ To: ________________

	Clinic				**Hospital**		**Ancillary**		**Other**
☐	Allergy	☐	Neurology	☐	Anesthesia Records	☐	CT/MRI	☐	Immunization Record
☐	Audiology/Cochlear	☐	Ophthalmology	☐	Behavioral Health/IRTC	☐	EEG	☐	Itemized Billing Records
☐	Craniofacial	☐	Orthopedic	☐	Consultation Reports	☐	EKG	☐	Nutrition
☐	Ear, Nose, Throat	☐	Pediatric	☐	Discharge Summary	☐	Lab	☐	School/Work Release
☐	GI	☐	Psychiatry	☐	History & Physical	☐	Sleep Study	☐	Verbal Communication
☐	Internal Medicine	☐	Speech & Language	☐	Operative Report	☐	X-ray		
Other:									

Purpose for which information is to be used:

☐ Treatment/Referral ☐ Insurance ☐ Evaluation
☐ Changing Doctors ☐ Personal/At Request of Patient ☐ Other (Please specify)

State and federal law protect the following information. Please check the box if you want to include this information with your records.

☐ Alcohol, Drug, or Substance Abuse Records ☐ HIV Testing & Results

Release Format: ☐ Paper ☐ CD/DVD **Release Method:** ☐ Mail ☐ Pick up ☐ Fax ☐ Email ☐ Portal

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to ____ Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire in one year from the date signed or on the following date/event/condition ______________________________, whichever occurs sooner.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

____ ____
Patient or person authorized to sign for patient Relationship to Patient

____ ____
Witness Date

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