



## Authorization for Release of Protected Health Information

Patient's full name at the time of treatment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date(s) of treatment: \_\_\_\_\_

Purpose of release: \_\_\_\_\_

I authorize the following provider/entity \_\_\_\_\_ to release my health information to:

Recipient/Provider Name: \_\_\_\_\_

Recipient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Mail Record     I will pick-up     FAX (to health provider or health plan only)     I request a copy of this authorization

### Information To Be Released: (Please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Bill<br><input type="checkbox"/> Cytology Reports<br><input type="checkbox"/> Diagnosis List/Patient Identification<br><input type="checkbox"/> Emergency Department Records<br><input type="checkbox"/> EKG/Cardiovascular<br><input type="checkbox"/> Laboratory Report (type) _____<br><input type="checkbox"/> Mammography Films<br><input type="checkbox"/> Occupational Therapy Reports<br><input type="checkbox"/> Office Notes (type) _____ | <input type="checkbox"/> Pathology Reports<br><input type="checkbox"/> Physical Therapy Reports<br><input type="checkbox"/> Physician Dictation (type) _____<br><input type="checkbox"/> Pulmonary Function Test<br><input type="checkbox"/> Radiology Film (type) _____<br><input type="checkbox"/> Radiology Reports<br><input type="checkbox"/> Speech Therapy Reports<br><input type="checkbox"/> Other: _____ |
|--|--|

1. I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2. I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of the form.
4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5. I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.
6. I understand that a copy or FAX of this document is just as valid as the original document.
7. I understand that this authorization will expire 90 days after signed unless an earlier date is specified here \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Telephone Number

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Reason Patient is Unable to Sign

**PROVIDER  
USE ONLY**

Original to Medical Records: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_ Copy to: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_

Verification Completed By: \_\_\_\_\_