

AUTHORIZATION TO RELEASE / OBTAIN PROTECTED HEALTH INFORMATION

(Pursuant to 45 C.F.R. 164.508)

Patient Name _____

Date of Birth _____

Medical Record# _____

SS # _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name / Address / Phone Number of Individual / Facility
To Receive PHI: (Must Have Address and / or Fax Number)

Name / Address / Phone Number of Individual / Facility
To Disclose PHI:

Please read carefully: Information authorized for use or disclosure, or to be obtained:

- | | |
|--|---|
| <input type="checkbox"/> History / Physical / Consultation Report | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Summary of Hospitalization | <input type="checkbox"/> Ultrasound Reports |
| <input type="checkbox"/> All Medical Records to include original chart | <input type="checkbox"/> Other _____ |

Date(s) of service: _____ to _____

The information will be obtained, used, or disclosed for the following purpose(s) only:

- | | | |
|--|--|--|
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal | <input type="checkbox"/> At the request of the patient or patient's representative |
| <input type="checkbox"/> Continued Treatment | <input type="checkbox"/> Other (Specify) _____ | |

I further understand:

- I may refuse to sign this authorization and my refusal will have no impact on receiving treatment or payment or to enroll or be eligible for benefits.
- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: _____
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of protected health information covered by this authorization. The recipient for the disclosure will not compensate the entity authorized to disclose the information.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease. I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

Signature of Patient or Legal Representative

Date

Description of Legal Representative's Authority

Expiration Date of Authorization

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances, including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is

disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court of the Department of Health, or by law.