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:

- ☐ History / Physical / Consultation Report
- ☐ Summary of Hospitalization
- ☐ All Medical Records to include original chart
- ☐ Lab Reports
- ☐ Ultrasound Reports
- ☐ Other _____

Date(s) of service: _____ to _____

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

☐ Insurance ☐ Legal ☐ At the request of the patient or patient's representative
☐ Continued Treatment ☐ 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.