

Authorization for Release of Protected Health Information

Patient Name: _____ **DOB:** _____
Street Address: _____
City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

This Release Authorizes: Facility Name: _____
 Address: _____
 Phone: _____ Fax: _____

To Release To: Facility Name: _____
 Address: _____
 Phone: _____ Fax: _____

Please specify the type of information to be disclosed below: (There may be a fee to process this request)

- | | |
|--|--|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Surgical/Hospital Reports | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Radiology(Reports/Films) | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> All Available or Specific Date Listed _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> All Available or Specific Date Listed _____ |

This information is to be used for: Medical Care Personal Other: _____

Drug and/ or Alcohol Abuse, Communicable Disease, Psychiatric, HIV/AIDS, and/or Genetic Testing Release:

I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Diseases, Psychiatric, and/or Genetic Testing may be released. YES (Initial) NO (Initial)

I agree that any medical or billing record containing information regarding HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment may be released YES (initial) NO(initial)

I understand that I can revoke this authorization any time by submitting a written request to the medical records departments at the location where the records are stored. I also understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA) of 1996.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

Patient/ Authorized Representative Signature: _____ **Date:** _____

Relationship to Patient: _____ **Witness:** _____