

Authorization for Release of Protected Health Information

Patient Identification

Printed Name: _____ **Date of Birth:** _____

Address: _____

Social Security #: _____ Telephone: _____

Authority to Release Protected Health Information

I hereby authorize _____ to release the information identified in this authorization form from the medical records of _____ and provide such information to _____.

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

<input type="checkbox"/> Complete health record	<input type="checkbox"/> Diagnosis & treatment codes	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> Complete billing record	<input type="checkbox"/> Itemized bill

Other, (specify)

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be “at the request of the individual”):

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. **Check One:** **Yes** **No**

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:** **Yes** **No**

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to _____ at _____. Unless revoked, this authorization will expire on the following date, or after the following time period or event _____

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if healthcare services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test). I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. **I hereby release and discharge** _____

of any liability and the undersigned will hold _____ harmless for complying with this Authorization.

Signature: _____ **Date:** _____

Description of relationship if not patient:
