AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name	Date of Birth	Today's Date
Patient's Address City State Zip		
Phone #		

By signing this form, I authorize the release of PHI (medical records) to the following:

Person or organization	□Release to self	□Records pick-up
Address		
Phone	Fax	

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **This authorization will remain in effect for one (1) year or until I revoke it in writing.**

INFORMATION TO BE DISCLOSED:

The following PHI may be released (check boxes below):			**I further authorize the release of information which may be included in the PHI:**
□ History and Physical	□ Operative Report (s)	□ Discharge Summary	□ Behavioral Health
□ Problem List	□ Medication List	□ Clinic/Office Notes	□ Substance Use Disorder
□ Emergency Room Record	□ Radiology Reports	□ Lab/Pathology Reports	□ STD/HIV/AIDS Treatment or Tests
□ Billing Records	□ Radiology Images	□ Other:	

Are specific dates needed?	Write dates below:

PURPOSE OF DISCLOSURE:

□ Personal Use □Follow-up Healthcare □Insurance Purposes □Other (specify) _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of patient or legal representative Date

Complete the section below only if the person requesting records is not the patient		
Name of Representative	Relationship to patient	Legal Authority
Representative's Address & Phone Number	Verification of Identity (internal use only)	Verification of Authority (internal use only)

Date received _____ **Date Information Released:** _____ **Account #** _____

Person releasing information: _____ **Verification of identity of requestor** _____ **ID checked**