AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name ______________________________ Previous last name(s) ______________________________

Address ______________________________ Date of Birth ______________________________

City, State, Zip Code ______________________________ Phone ______________________________

I authorize the use and/or disclosure of my protected health information:

I understand that my protected health information that I am authorizing to be disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), infection with the Human Immunodeficiency Virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. **If I do not intend for this information to be disclosed, I understand that I will need to cross out the statement above and initial here.** __________

FROM:

Organization/Provider ______________________________

Address ______________________________

City, State, Zip ______________________________

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TO:

Organization/Individual ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ______________________________

Information to be disclosed includes: **Body Part:** ______________________ **Injury:** ______________________

Hospital Record:

- ☐ Discharge Summary
- ☐ Emergency Report
- ☐ History & Physical
- ☐ Consultations
- ☐ Lab/Pathology Reports
- ☐ EKG Reports
- ☐ Operative/Procedure Report
- ☐ Radiology/X-Ray Reports
- ☐ Other ______________________________

Clinic Record:

- ☐ Office Visit Notes
- ☐ Radiology/X-Ray Reports
- ☐ Lab/Pathology Reports
- ☐ EKG Reports
- ☐ Other ______________________________

Delivery Method:

- ☐ Pick-Up
- ☐ Mail
- ☐ Other ______________________________

Date Range of Services: ______________________________

Purpose for disclosure (Optional):

- ☐ Medical Care
- ☐ Insurance
- ☐ Legal
- ☐ Personal
- ☐ Disability Determination
- ☐ Worker's Compensation
- ☐ Law Enforcement
- ☐ Social Services
- ☐ Other (specify): ______________________________

Fees: I understand that fees may apply to process my medical record request.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event (Specify):

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I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

______________________________ ______________

Signature of Patient Date

______________________________ ______________ ______________

Signature of Parent/Legal Representative Relationship Date

Revised 09/2022