



AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. I hereby voluntarily authorize the disclosure of protected health information for:

Patient Name: _____ **DOB:** _____
Address: _____ **Zip Code:** _____
Record Number (if known): _____

II.	The information is to be disclosed by:	And is to be provided to:
	Name of Facility	Name of person/organization/facility
	Address	Address
	Phone Number	Phone Number

III. **The purpose or need for this disclosure is:**

- ☐ Continuing Care Purposes ☐ Legal Purposes ☐ Insurance Purposes ☐ At the Request of the Individual
☐ Other (Specify) _____

IV.

Please disclose the following information for these dates of service: _____ **to** _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Medication List | <input type="checkbox"/> Therapy Evaluations |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Discharge Records | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Other (Specify): _____ | | |

I authorize the provider to use or disclose information related to the following sensitive information:

- | | |
|---|---|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Psychotherapy (by checking this box, I am waiving any psychotherapist-patient privilege) |
| <input type="checkbox"/> Any other sensitive health information | |

Signature Required:

V.

- ☐ I understand that the provider will not condition treatment, payment, enrollment, or eligibility on obtaining this authorization, except where federal law allows such condition.
- ☐ I understand that I may inspect or copy the information the provider seeks to use or disclose, and that I may refuse to sign this authorization.
- ☐ I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal law and may be disclosed by the recipient.
- ☐ I understand this authorization may be revoked in writing submitted at any time to the Medical Records Department unless the provider has taken action in reliance on this authorization.
- ☐ I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- ☐ Unless I revoke this authorization, it will expire 60 days following the date, event, or condition, unless a new date is entered here: _____

VI.

- ☐ I understand that should I choose to receive these copies in paper format, a copying fee will be incurred. I understand that should I choose to receive these copies in electronic format, no fees will be incurred. I understand that should I choose to have these paper copies or encrypted USB drive mailed to me, a postal fee will be incurred as well. I understand that all fee schedules are available upon request and that payments will be required in full upon receipt of the records.

VII.	Signature of Patient or Personal Representative (State relationship to patient)	Date
	Signature of Facility Representative releasing this information	Date
	Signature of Witness (If first signature is a thumbprint, mark or verbal release)	Date