Authorization for Release of Protected Health Information

Patient Identification

Name:_____ **DOB**_____

Address:_____ **SS#** _____

_____

_____

_____ _____

Information is to be released by **Information is to be released to**

_____ _____

Street address **Street address**

_____ _____

City, State and Zip Code **City, State and Zip Code**

_____ _____

Telephone **Telephone or Fax ____ (please check if to be sent to fax)**

INFORMATION TO BE RELEASED-COVERING THE PERIODS OF HEALTH CARE

From (date)_____ **to (date)**_____

PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED

Complete Health record___Billing____Diagnosis/Treatment Codes___Discharge Summary__Lab Results__Xray results____

Other (specify)_____

Purpose of request_____

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**_____

TIME LIMIT & RIGHT TO REVOKE AUTHORIZATION

Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Records Department or other department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date_____ or 90 days from date of signature, unless otherwise specified.

RE-RELEASE

I understand the information released pursuant to this authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

Your provider will not deny treatment if you do not sign this form. BY SIGNING BELOW, YOU AUTHORIZE YOUR PROVIDER, IDENTIFIED, TO RELEASE YOUR PROTECTED HEALTH INFORMATION SPECIFIED ABOVE AS WELL AS AGREE TO PAY ANY FEES THAT MAY APPLY.

SIGNATURE_____ **DATE**_____

AUTHORITY TO SIGN (IF NOT PATIENT)_____ **WITNESS**_____

Identity of requestor verified via: photo ID:____ matching Signature:__ other, specify_____**ID verified by** _____