Patient Authorization for Release of Protected Information

Patient Name: _____ Patient Phone #: _____

Address: _____

Date of Birth: _____ Medical Record Number: _____

I authorize the disclosure and use of health information as described below:

1. Who may disclose (give out) this information:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Fax Number /or/ Email Address (if applicable)

2. Who may receive and use this information:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Fax Number /or/ Email Address (if applicable)

3. What format is the information to be disclosed in:

Note: If records consist of more than 10 pages or if no selection is made paper copies will be sent via US Postal Service.

□ Mail □ Fax □ Email □ Electronic copies (disk mailed)

4. The purpose for which this information may be disclosed:

□ For treatment □ For care coordination □ Payment □ At the request of the individual listed above

□ Other _____

5. What information may be disclosed:

□ Last year of medical records (provided free of charge)

□ All medical records ($10 retrieval & copy fee)

□ Lab results from _____ to _____

□ X-ray/Imaging results from _____ to _____

□ Consultation reports from (please supply doctor's name):
_____

□ Other (as described here):
_____

6. This authorization expires (ends) twelve (12) months from the date I sign this form, unless otherwise indicated below.

On the following date, event or condition: _____

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the facility listed above
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or copy the health information to be disclosed.
- If the disclosed information goes to a health care provider or health plan covered by federal privacy laws, federal privacy laws will protect it.
- I have a right to request the method in which my information is provided.
- Information that goes to other persons or entities may not be protected by state of federal privacy laws and may be re-disclosed
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form.
- Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose or creating personal information for a third-party, such as life insurance companies.
- A copy of this release may be used as the original form.

*** Please note:** This form must be filled out in its entirety. Incomplete information, sections or missing payment (if applicable) will result in this form being returned to the patient for completion and/or payment. Please allow 10 business days for the processing of your request. Thank you.

_____ _____

Signature of Patient or Patient's Representative *Date*

_____ _____

Print representatives name (if signed by patient's representative) *Relationship to patient*

FOR INTERNAL USE ONLY:

Records/Information compiled by: _____ Reviewed by: _____

Completed By: _____ Approved: _____