


AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)		
PATIENT NAME (Last,First,Middle)		DOB
ADDRESS		SSN
CITY	STATE	ZIP
PROVIDER AUTHORIZED TO RELEASE THE PHI		ENTITY RECEIVING THE PHI
NAME		NAME
		ADDRESS
ATTENTION	CITY/STATE/ZIP	
This authorization will expire on the following date or event	DATE	EVENT
PURPOSE OF THIS DISCLOSURE:		
PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE		
Description	StartDate	End Date
<input type="checkbox"/> All PHI in the record		
<input type="checkbox"/> Progress Notes		
<input type="checkbox"/> Laboratory Tests		
<input type="checkbox"/> X-Ray Tests/Reports		
<input type="checkbox"/> History and Physical Examination		
<input type="checkbox"/> Consultation Reports		
<input type="checkbox"/> Itemized Billing Statement		
<input type="checkbox"/> Other		
I UNDERSTAND THAT:		
1. I may refuse to sign this authorization, and it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but it will not have any effect on any actions taken prior to receiving the revocation. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and maybe disclosed. 5. I have the right to receive a copy of this form after I sign it.		
Signature of Patient		Date
Signature of Patient's Representative (if necessary)	Relationship to Patient	Date