

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	
		ADDRESS	
		CITY	STATE ZIP
		ATTENTION:	
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	Start Date	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:			
<p>I UNDERSTAND THAT:</p> <ol style="list-style-type: none"> 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 I do, 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 may be 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)		Date	
Personal Representative's Relationship to Patient			