



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN MEDICAL RECORDS

PATIENT IDENTIFICATION:

Patient's full name: _____ Phone: _____

Full address: _____

Other name(s) used: _____ Date of birth: _____

Both sections must be completed

DISCLOSE/COPY MY MEDICAL RECORDS FROM:

Person/organization name: _____

Full address: _____

Phone: _____ Fax: _____

SEND MY MEDICAL RECORDS TO:

Person/organization name: _____

Full address: _____

Phone: _____ Fax: _____

Email (for delivery by secure email): _____

REASON FOR DISCLOSURE:

- Treatment/continuing care
- Personal use
- Billing or claims
- Legal purposes
- Insurance / disability
- Email
- Other: _____

FORMAT OF DELIVERY:

(Honored when possible.)

- Mail – Paper
- Mail – CD / DVD
- Fax
- Email
- Other: _____

DISCLOSE THE FOLLOWING PHI IN MY MEDICAL RECORDS: Mark all that apply.

Date range, if applicable: _____

- All health information
- Clinician orders
- Clinician notes
- Billing information
- Procedure reports
- Lab reports
- Radiology __ Reports __ Images
- Consultation reports
- Other _____

Your initials are required if you **DO NOT** want to release any of the following sensitive information:

- ____ Mental health records (excluding psychotherapy notes)
- ____ Drug, alcohol, or substance abuse records
- ____ Genetic information (including genetic test results)
- ____ HIV/AIDS test results / treatment
- ____ Reproductive health

I freely authorize the named person/organization to release my medical records to the named person/organization with the understanding that:

1. A photocopy or fax of this authorization is as valid as this original.
2. I may revoke this authorization at any time in writing, except where information has already been released.
3. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
4. I do not need to sign this form in order to ensure healthcare treatment, payment, enrollment or eligibility.

Signature of patient or parent / legal guardian

Date

Relationship to patient¹

Expiration date of authorization²

1. Please note: If you are a guardian or court-appointed representative, you must attach a copy of your legal authorization to represent the patient, except in the case of the parent of a minor patient. 2. Unless noted, authorization expires 1 year from date of signature above.