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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

To disclose the following specific medical information:

Name: ____
(Primary Care Physician, Family Physician, Pediatrician, E.N.T., or other Healthcare provider)

Address: ____

City/State/Zip: ______________________________ **Phone:** (________) ______________

From the health records of:

Name: ____
(Patient's name or parent/guardian name, if minor)

Address: ____

City/State/Zip: ______________________________ **Phone:** (________) ______________

Purpose of Disclosure:

____

____

Please check all that apply:

( ) All PHI in record
( ) History and Physical
( ) Consult Report
( ) Operative Report
( ) Progress Notes
( ) Physician Orders
( ) Laboratory
( ) Imaging/ Radiology
( ) Nursing Notes
( ) Medication Record
( ) Demographics
( ) Rehabilitation Services
( ) Special Test / Therapy
( ) Itemized Bill Claims
( ) Other:

I understand that:

1. I may refuse the right to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. 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 re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.

SECTION C:

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative: ______________________________ Date: ______________

Print Name of Patient's Representative: ______________________________ Relationship to Patient: ______________