



Authorization to Disclose Protected Health Information
This form is for all record requests

Release Information From: Specify Provider/Organization Name and Facility Address
Release Information To: Specify Provider/Organization Name and Facility Address
Organization Name:
Address:

By signing this Authorization, I authorize my health care provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENTS FULL NAME

MAIDEN OR OTHER NAME

DATE OF BIRTH / / SSN/MEDICAL RECORD #

ADDRESS

Mailing Address, City, State, Zip

Covering the period(s) of health care:

FROM (Date) / / TO (Date) / / All encounter dates

1. Information authorized for disclosure, if included in my records:

- Complete health record
Visit/Discharge Summary
Clinical Documentation of Physical
Documentation of consultation
Immunization Records
Progress Reports
Radiology and Diagnostic Imaging Reports
Photographs, Videos, Digital or Other Images
Pathology Reports
Laboratory tests (please specify)
Other (please specify)

2. If applicable, I also give permission for the following "Sensitive PHI" to be disclosed (please check below):

- Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
Behavioral Health Services / Psychiatric Care
Treatment for Alcohol and/or Drug Abuse
Sexually Transmitted Diseases (STD)
Genetic Counseling / Testing



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3. The purpose for which disclosure is authorized (check where applicable):

- Medical Care Insurance Benefit eligibility Immunization

Other: _____

4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

EXPIRATION DATE ____ / ____ / ____

5. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that the information disclosed pursuant to this authorization, **except** information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

Signed: Patient—(or Legal Representative, Parent or Legal Guardian)	Date ____ / ____ / ____
(Relationship if not Patient)	