## Authorization to Disclose Protected Health Information



Patient Information	Name:	Date of Birth:	
	Address:	Day Phone:	
	City:	State:	Zip:
Hospital/Clinic/Health Care Provider (Who has the information you want released? Please list the specific hospital and/or clinic.)	Facility Name:		Phone:
			Fax:
	Facility Name:		Phone: Fax:
	Facility Name:		
			Fax:
<b>Receiving Party</b> (Where do you want the infor- mation sent? Who may have the information?)	Name:		
	Address: Day Phone:		
	City: Fax Number:		
Information to be	Date range of information to be	released: From:	To:
Released (What do you want sent or released? Check the appropriate box.)		released: From: (Month/Year)	(Month/Year)
	Please check specific information to be released:		
	Provider reports		
	Discharge Summary/Instruct Emergency Record	ions   Laboratory Repo  Pathology Repor	
	□ Other		
	□ Imaging □ reports □ films/CD		
Release Instructions (How and when do you want	Date information is needed: Disclosure Method:		
the information?)	Email Address		
	□ Other		
	Note: *Fees may be charged in accordance with Federal and State law.		
Purpose of Release (Why records are needed)	□ Patient request □ Transfer of care □ Follow-up care □ Continuing Care □ Litigation/Legal □ Insurance Payment/Claim □ Other		
<ul> <li>By signing this authorization form, I understand that:</li> <li>The information in the health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) and genetic information. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.</li> <li>This authorization does not apply to psychotherapy notes.</li> <li>Once the information described herein is disclosed, it could be redisclosed by the recipient and may not be protected by privacy protections.</li> <li>I have the right to revoke this Authorization at any time. Revocation must be in writing and presented to Health Information Management (fax 756-3523). Revocation will not apply to information that has already been disclosed in response to this Authorization.</li> </ul>			
• Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.			
<ul> <li>Requests for copies of health records are subject to reproduction fees in accordance with Federal and State law.</li> <li>I will receive a copy of this Authorization.</li> </ul>			
Unless otherwise revoked, this Authorization will expire on the following date: If I fail to specify an expiration			
date/event/condition, this Authorization will expire six (6) months from the date it is signed.			
Signature of Patient or Legal Representative		Printed Name	Date
If Signed by Legal Representative, Relationship to Patient		Signature of Witness	Printed Name
For Office Use Only:         Signature/ID verified       Yes       No       Completed by (Name/Date)			
# of pages released			
<b>Revocation Authorization</b> I hereby revoke (cancel) this Authorization to Disclose Protected Health Information.			formation.
	Cancellation Signature:		Date: