

Authorization for the Release of Protected Health Information (PHI)

This authorization form has been specifically designed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In order for this authorization to be considered valid, it must be completed in its entirety.

I AUTHORIZE (NAME OF THE INDIVIDUAL OR ORGANIZATION)

ADDRESS: _____

TO RELEASE INFORMATION AND/OR COPIES OF MEDICAL RECORDS FOR THE FOLLOWING PATIENT:

PATIENT NAME: _____ DOB: _____

SSN#: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE: _____

SPECIFIC INFORMATION TO BE RELEASED:

_____ DISCHARGE SUMMARY	_____ OPERATIVE NOTE	_____ HISTORY AND PHYSICAL
_____ CONSULTATION	_____ X-RAY REPORTS	_____ PATHOLOGY
_____ LAB REPORTS	_____ ABSTRACT (ALL PERTINENT RECORDS AS DESCRIBED)	
_____ ENTIRE RECORD	_____ OTHER (PLEASE SPECIFY)	

DATE OF TREATMENT (S): _____

PURPOSE OF DISCLOSURE: _____

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION PERTAINING TO TREATMENT FOR PSYCHIATRIC ILLNESS, SUBSTANCE ABUSE OR THE HIV VIRUS. I HEREBY CONSENT TO THE RELEASE OF THIS INFORMATION.

RECORDS ARE TO BE RELEASED TO:

NAME: _____

ADDRESS: _____

THIS AUTHORIZATION IS VALID UNTIL _____ [A DATE MUST BE FILLED IN HERE IN ORDER TO PROCESS THIS AUTHORIZATION.] AND MAY BE REVOKED AT ANY TIME IN WRITING PRIOR TO THE EXPIRATION OF SUCH 90-DAY PERIOD. REVOCATON OF THIS AUTHORIZATON SHALL NOT AFFECT RELEASES MADE PRIOR TO THE REVOCATION.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION IS VOLUNTARY AND THAT I NEED NOT SIGN THIS AUTHORIZATION IN ORDER TO ASSURE MEDICAL TREATMENT. I FURTHER UNDERSTAND THAT THE DISCLOSURE OF THIS INFORMATION CARRIES WITH IT THE POTENTIAL FOR UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

I CERTIFY THAT I HAVE THE AUTHORITY TO APRPOVE THE REQUESTED RELEASE OF INFORMATION AND TO SIGN THIS AUTHORIZATION.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN/PERSONAL REPRESENTATIVE
SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____ PLEASE PRINT NAME: _____