AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)							
Patient Name	Date of Birth			h		Today's Date	
Patient's Address			City		State		l Zip
Phone #							
By signing this form, I authorize the release of PHI (medical records) to the following:							
Person or organization Rele						to self	□Records pick-up
Address							
Phone Fax							
Tun							
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This authorization will remain in effect for one (1) year or until I revoke it in writing.							
INFORMATION TO BE DISCLOSED:							
The following PHI may be released (check boxes below):						of info	er authorize the release rmation which may be ed in the PHI:
☐ History and Physical	□ Operati	ve Report (s)	□ Discha	arge Summary	'	□ Beha	vioral Health
□ Problem List	□ Medica		☐ Clinic/Office Notes			☐ Substance Use Disorder	
□ Emergency Room Record	□ Radiolo	gy Reports	□ Lab/P	athology Repo	orts	□ STD/ Tests	HIV/AIDS Treatment or
☐ Billing Records	□ Radiolo	□ Radiology Images □ Other:					
Are specific dates needed?	Write dates below:						
PURPOSE OF DISCLOSURE:							
□ Personal Use □Follow-up Healthcare □Insurance Purposes □Other (specify)							
I understand that I have a 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 Health Information Management Department. 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 with the right to contest a claim under my policy.							
I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.							
Signature of patient or legal representative Date							
Complete the section below only if the person requesting records is not the patient							
Name of Representative	Relationship to patient Lega			Legal A	ll Authority		
Representative's Address & Phone	Verification of Identity (internal use only) Ver			Verifica	ification of Authority (internal use only)		
Date received Date Information Released: Account #							

Verification of identity of requestor

ID checked

Person releasing information: