

**AUTHORIZATION FOR RELEASE OF  
PROTECTED PATIENT HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

1. I hereby authorize \_\_\_\_\_ to: \_\_\_\_\_ obtain my information from, **OR** \_\_\_\_\_ release my information to: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

2. I authorize the following information to be released: \_\_\_\_\_ Treatment Dates: \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Summary Sheet        | <input type="checkbox"/> Progress Notes            | <input type="checkbox"/> Discharge Summary       |
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> Operative Report(s)       | <input type="checkbox"/> Consultation Reports    |
| <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> Radiology Report(s)/ Film | <input type="checkbox"/> Pathology Report(s)     |
| <input type="checkbox"/> Endoscopy Report (s) | <input type="checkbox"/> Physical Therapy          | <input type="checkbox"/> ER Record               |
| <input type="checkbox"/> EKG(s)               | <input type="checkbox"/> CT/MRI Report(s)/ Film    | <input type="checkbox"/> Complete Medical Record |
| <input type="checkbox"/> Clinic Record(s)     | <input type="checkbox"/> Nurse Note(s)             | <input type="checkbox"/> Physician Orders        |
| <input type="checkbox"/> Other: _____         |  |  |

3. **There are no limitations** placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health, behavioral or psychiatric treatment.

**SIGNER MUST INITIAL THIS CLAUSE: \_\_\_\_\_ OR QUALIFY THE ABOVE: \_\_\_\_\_**

4. **The above information is released for the following purpose and that purpose only:**

\_\_\_\_\_ Continuation of Care    \_\_\_\_\_ Legal Purposes    \_\_\_\_\_ Insurance Purposes    \_\_\_\_\_ Employer Requirement  
\_\_\_\_\_ Personal Reasons    \_\_\_\_\_ Other: \_\_\_\_\_

5. **Revocation Process:** I understand that I may, by placing my request in writing to the Privacy Officer, revoke this Authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy. This Authorization will expire 60 days from the date of my signature or as otherwise specified by date, event or condition as follows: \_\_\_\_\_.

6. **Right to Copy/Voluntary Disclosure:** I know I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

7. **Health Plan/ Insurance Issuers – Conditions:** I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan or eligibility for its benefits. If I am authorizing my information to be released to an insurance company, I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.

8. **Photocopy:** I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization; may deny the release of protected health information, if it has reason to believe (1) this authorization has been altered or (2) this is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which records are being requested.

\_\_\_\_\_  
Patient's Signature (Photo identification required)

\_\_\_\_\_  
Date (Must be within 60 days)

\_\_\_\_\_  
Signature of Other Individual

\_\_\_\_\_  
Relationship of Other to Patient

**Attach Document to Prove Authority to Act on Behalf of Patient**

**REDISCLASURE:** I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal confidentiality rules. **SIGNER MUST INITIAL THIS CLAUSE: \_\_\_\_\_**

**PROHIBITION OF REDISCLASURE:** Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.

Information has been released per authorization by \_\_\_\_\_ on date: \_\_\_\_\_  
(Patient)

Information Released by: (Employee) \_\_\_\_\_