

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient?** If yes, complete the Authorization for Research Form. If no, proceed to Section B.

**Section B: Required for all Authorizations for Release of PHI or Right to Access**

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY NO. (Optional): \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_ REQUESTOR'S NAME/PHONE NUMBER (IF PATIENT IS NOT THE REQUESTOR): \_\_\_\_\_

PHI RECIPIENT NAME: \_\_\_\_\_ ADDRESS/CITY/STATE/ZIP \_\_\_\_\_ PHONE NUMBER: ( ) \_\_\_\_\_

FAX NUMBER: ( ) \_\_\_\_\_

PHI SENDER NAME \_\_\_\_\_ ADDRESS/CITY/STATE/ZIP \_\_\_\_\_ PHONE NUMBER: ( ) \_\_\_\_\_

FAX NUMBER: ( ) \_\_\_\_\_

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE OF SIGNATURE

PURPOSE OF DISCLOSURE:

DESCRIPTION:	DATE(S)	DESCRIPTION:	DATE(S)	DESCRIPTION:	DATE(S)
<input type="checkbox"/> ALL PHI IN RECORD <input type="checkbox"/> HISTORY AND PHYSICAL <input type="checkbox"/> CONSULT REPORT <input type="checkbox"/> OPERATIVE REPORT <input type="checkbox"/> PROGRESS NOTES		<input type="checkbox"/> PHYSICIAN ORDERS <input type="checkbox"/> LABORATORY <input type="checkbox"/> IMAGING/RADIOLOGY <input type="checkbox"/> NURSING NOTES <input type="checkbox"/> MEDICATION RECORD		<input type="checkbox"/> DEMOGRAPHICS <input type="checkbox"/> REHABILITATION SERVICES <input type="checkbox"/> SPECIAL TEST/THERAPY <input type="checkbox"/> ITEMIZED BILL/CLAIMS <input type="checkbox"/> OTHER:	

I ACKNOWLEDGE, AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, PSYCHIATRIC, HIV TESTING, HIV RESULTS OR AIDS INFORMATION. \_\_\_\_\_ (INITIAL)  
 IF NOT APPLICABLE, CHECK HERE

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

**Section C: The request of PHI is for the purpose of marketing**

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?  Yes  No

If yes, describe:

**Section D: Signatures**

**I have read the above and authorize the disclosure of the protected health information as stated.**

SIGNATURE OF PATIENT/GUARDIAN/PATIENT REPRESENTATIVE: \_\_\_\_\_

DATE: \_\_\_\_\_

PRINT NAME OF PATIENT'S REPRESENTATIVE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_