Authorization for the Release of Protected Health Information

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Social Security Number:**

Provider's Name:	**Recipient's Name:**
____ ____ ____ **Phone #:** ______________________________	____ ____ ____ **Phone #:** ______________________________
Provider's Address: ____ ____ ____ **Fax #:** ______________________________	**Recipient's Address:** ____ ____ ____ **Fax #:** ______________________________

Description of Information to be Used or Disclosed

Description:	**Comments:**
☐ X-Ray Films ☐ X-Ray Report(s) ☐ MRI Films ☐ MRI Report ☐ Daily Chart Notes ☐ Other: ____________________	____ ____ ____ ____ ____

I understand that

1. I may refuse to sign this authorization and that is strictly voluntary. However, refusal to sign will render this form invalid.
2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
3. My treatment, payment, enrollment, eligibility for benefits may not be conditioned on signed this authorization.
4. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requestor 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.
6. There may be a reasonable fee to obtain a copy of the information being requested on this form.
7. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Section B: Required Signatures

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

____ ______________________________

Signature of Patient/Guardian/Personal Representative **Date Signed**

____ ______________________________

Printed Name of Patient/Guardian/Personal Representative **Relationship of Personal Representative to Patient**