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Protected Health Information Release Authorization

Step 1: Patient Information

Patient Name:_____ Date of Birth _____
Medical Record Number (if known): _____ Social Security Number _____

Step 2: Who has the records NOW:

Name of Provider/ Person / Facility: _____
Address: _____City: _____State: _____Zip code:_____
Phone: (____)_____ Fax : (____)_____

Step 3: To Whom do you wish to release your records TO?

Name of Provider/ Person / Facility: _____
Address: _____ City:_____ State: _____ Zip code: _____
Phone: _____ Fax : _____

Step 4: I authorize the release of the following health information and or records, if such exists:

_____
_____
_____
_____

Step 5: Protected Information :

Federal law protects certain sensitive information from release without specific authorization. I hereby consent to the release of references related to the following (you **MUST INITIAL EACH** line item)

_____Alcohol _____Drugs
_____Psychiatric _____HIV testing and/or AIDS diagnosis

Step 6: I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that treatment or payment is not contingent on me providing this authorization (except to the extent that the authorization is for research- related treatment, in which case you may refuse to provide that research-related treatment).

This authorization shall remain in effect from the date signed below until
Date_____

Patient Name: _____ Signature: _____
Relationship to Patient: _____ Date: _____