

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION



I hereby authorize use or disclosure of the named individual's health information as described below. I understand that medical information is considered Protected Health Information (PHI) under both Federal and State Privacy Laws. I also understand there may be a fee for copy services rendered.

Patient Name	Date of Birth	License Identification																																													
Address (Street, City, State, Zip Code)		Telephone Number																																													
Method of Release/Disclosure: <input type="checkbox"/> Mail <input type="checkbox"/> Pick up <input type="checkbox"/> Verbal Disclosure <input type="checkbox"/> Fax (Emergency Only) Fax #: _____																																															
This information may be disclosed to and used by the following individual or organization: (full address) 																																															
Treatment dates:	Purpose of Request:																																														
<p>The following information is to be disclosed: (please check)</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left; width: 5%;">Yes</th> <th style="text-align: left; width: 5%;">No</th> <th style="width: 90%;"></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Discharge Summary</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....History & Physical Examination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Consultations (including psychiatric evaluations)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Operative Report or Procedure Reports</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Emergency Department Record</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Laboratory Reports (including drug screens)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Radiology or Imaging Reports (X-rays, CT's, MRI's) (CD or Films) please circle</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Cardiac Cath Lab</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Physician Progress Notes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Medication Records</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Nursing Notes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Physician Orders</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Complete Record</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>.....Other _____</td></tr> </tbody> </table>			Yes	No		<input type="checkbox"/>	<input type="checkbox"/>Discharge Summary	<input type="checkbox"/>	<input type="checkbox"/>History & Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>Consultations (including psychiatric evaluations)	<input type="checkbox"/>	<input type="checkbox"/>Operative Report or Procedure Reports	<input type="checkbox"/>	<input type="checkbox"/>Emergency Department Record	<input type="checkbox"/>	<input type="checkbox"/>Laboratory Reports (including drug screens)	<input type="checkbox"/>	<input type="checkbox"/>Radiology or Imaging Reports (X-rays, CT's, MRI's) (CD or Films) please circle	<input type="checkbox"/>	<input type="checkbox"/>Cardiac Cath Lab	<input type="checkbox"/>	<input type="checkbox"/>Physician Progress Notes	<input type="checkbox"/>	<input type="checkbox"/>Medication Records	<input type="checkbox"/>	<input type="checkbox"/>Nursing Notes	<input type="checkbox"/>	<input type="checkbox"/>Physician Orders	<input type="checkbox"/>	<input type="checkbox"/>Complete Record	<input type="checkbox"/>	<input type="checkbox"/>Other _____
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Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.																																															
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information already released based on this authorization.																																															
Expiration: Unless otherwise revoked, this authorization will expire in 6 months (180 days) from the date of my signature. Otherwise, specified date of expiration: _____																																															
Redisclosure: 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 redisclosed.																																															
Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.																																															
Signature of Patient or Authorized Party:		Date																																													
Print Name of Patient or Authorized Party: (and relationship to Patient, if necessary)																																															