AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION[1]

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES.

THERE IS A CHARGE OF $0.63 PER PAGE UP TO 250 PAGES AND $0.45 PER PAGE THERAFTER UNLESS BEING SENT TO A HOSPTIAL/HEALTHCARE PROVIDER. *AN ADDITIONAL CHARGE OF $18.97 MAY ALSO BE CHARGED FOR SUPPLIES AND LABOR.*

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

Records to be disclosed:

CHECK ONLY ONE OF THE FOLLOWING BOXES (A or B).

If neither box is checked or if both boxes are checked then this form will be considered defective and cannot be used. IF YOU WANT BOTH TYPES OF RECORDS DISCLOSED YOU MUST USE TWO SEPARATE FORMS – One for Each Purpose.

☐ A. Records *except* for Psychotherapy Notes ☐ B. Psychotherapy Notes only.

DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED *(examples: All records, X-Rays only, records for last 12 months)* AND/OR CHECK ALL THAT APPLY: ☐**All Records*** ☐**alcohol/drug evaluation or treatment** ☐**HIV/AIDS Status**

_____

***"**All records" means all protected health information in a designated record set, which includes but is not limited to patient family histories, genetic information, inpatient/outpatient records, medical, dental, psychiatric, alcohol/chemical/substance abuse, HIV/AIDS, pharmaceutical, hospital or physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).

Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:

Persons, facility, or class of persons who are authorized to receive the records/information:

Expiration: This "Authorization" will expire on _____(MM/DD/YY) or on the following specific event:_____

If no expiration date or event is listed unless otherwise revoked this authorization will expire in 1 year.

- This request for disclosure of medical records/information is made at my request for (state reason for the disclosure:_____ .
- I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
- I also understand that I may revoke this authorization at any time by delivering/mailing a *written* revocation to the party or attorney or law firm named in Block 4 above.
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____

Signature of Patient (or Patient's Personal Representative, if applicable) Date

Personal Representative's Relationship/Capacity to Patient:_____

Printed Name of Personal Representative: _____

Printed address & telephone number of Personal Representative_____

_____

Authoriztion Completed by: _____ Date: _____ Faxed _____ Mailed _____ Pt to pick up _____