# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*Complete One Form Per Patient*

**PATIENT INFORMATION:**

| ______________________________ | ______________________________ |
|---|---|
| Name | Date of Birth |
| Street Address City, State, Zip Code | Social Security |
| Email Address | Phone Number |

| **RELEASE MEDICAL RECORDS FROM:** | **RELEASE MEDICAL RECORD TO:** |
|---|---|
| Entity Name | Entity Name |
| Phone Number | Phone Number |
| Street Address | Street Address |
| Email Address / Fax Number | Email Address / Fax Number |

**DATES OF SERVICE:** (REQUIRED) ____/____/____ to ____/____/____

**MEDICAL RECORDS TO BE RELEASED:** (REQUIRED)

__Office Visits  __Radiology Reports  ___Pathology Reports  ___Imaging

__ECG  __Laboratory Reports  ___Discharge Summary  ___Other

(REQUIRED) ___ I DO___I DO NOT authorize the release of sensitive information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse (INITIALS): ______

**PURPOSE OF RELEASE:** (REQUIRED)

____Personal ____Referral to Specialist ____Disability Determination _____Insurance ______Legal Investigation

___Transfer of Care to a New Provider - You must notify your Insurance Carrier of the Change in Provider (INITIALS): ________

For Transfer of Care, please indicate the reason for transfer: ( ) Moving out of State ( ) Change of Insurance ( ) Transfer to Adult PCP ( ) Other (please specify) ______________________________

**SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER):**

I acknowledge I am a legal representative, or an authorized person of the patient listed above. By signing below, I am authorizing the release and disclosure of the patient's protected health information. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request with written notification, and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

| ______________________________ | ______________________________ |
|---|---|
| Signature of Legal Representative/Patient 18 yrs or older | Date |
| Printed Name of Legal Representative/Patient 18 yrs or older | Relationship to Patient |