



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____

Date of Birth: _____

Address: _____

Social Security #: _____

Home Phone Number: _____

Work Phone Number: _____

I authorize the named provider to release and/or obtain my "protected health information" to:

- Mail Records to: _____
- Obtain Records from: _____
- I will pick up _____

Information for treatment period: From (Date)_____ To(Date)_____

Information to be released :(Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Patient Identification | <input type="checkbox"/> Office Notes/Physician Dictation | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> EKG/Cardiovascular | <input type="checkbox"/> Radiology Films Type _____ | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Physical Therapy Records | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Pulmonary Function Test | <input type="checkbox"/> Bill | <input type="checkbox"/> OTHER: _____ |

This information is being requested for the follow purpose(s): _____

Sensitive information: I understand that my record may include information relating to acquired immunodeficiency syndrome (AIDS), or HIV. Infection, Psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Signature of Patient or Legal Representative _____

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already released based on this information.

Signature of Patient or Legal Representative _____

EXPIRATION: I understand that this authorization will expire 12 months after signed unless earlier date is specified here _____

CHARGES: I understand that there maybe a charge for obtaining the requested information.

Signature of Patient or Legal Representative

Date