



*Patient Name: _____ Medical Record #: _____

*Patient Address: _____ City: _____ State: _____ Zip Code: _____

* Social Security #: _____ *Date of Birth: _____

* Patient Phone # (including area code): Home: _____ Cell: _____

*I hereby authorize _____
Name of Person/Organization Disclosing PHI

To release the following information to Person/Organization Receiving PHI:

*Name, Address, Phone, Fax	*Relationship	*Purpose

***Information to be shared:**

- Records for dates of service between _____ and _____
- Pertinent Information (includes physician notes and diagnostic results)
- Entire Medical Record (includes all records except Psychotherapy Notes)
- Psychotherapy Notes (if checking this box, no other boxes may be checked)
- Mental Health Records (except Psychotherapy Notes)
- Substance Abuse Treatment Records
- Billing Information

Other: _____

The information may be disclosed for the following purposes(s) only:

- Insurance Continued Treatment Legal At my or my representative's request

Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.

- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:

* _____
Signature of Patient or Legal Representative

* _____
Date

* _____
Print Patient or Legal Representative

* _____
Expiration date (if longer than one year from date of signature or no event is indicated)

* _____
Description of Legal Representative's Authority

**Required field*

(INTERNAL USE ONLY)

1) Number of pages released: _____

2) If releasing records following a verbal modification by the requestor, please describe below:

Specific documentation released:

a. Pertinent Only _____

b. Other _____

3) Staff initials: _____ Date: _____

4) Verification of authorized receiver:

a. License _____

b. Photo ID _____

c. Other (describe) _____

5) Authorized Receiver:

a. Name: _____

b. Signature: _____ Date: _____

Title

Instructions for

1. Indicate patient name and date of birth.
2. OPTIONAL: Indicate Medical Record # and/or Social Security #.
3. Indicate the name of person/organization disclosing PHI.
4. Indicate the name and address of person/organization receiving PHI.

Information to be shared:

1. Check the appropriate box.
2. If the information to be shared is not listed, check the "other" box and indicate what information is to be shared in the space provided.
 - a. If billing information is shared, indicate which billing information is requested. If all billing information is requested, just check the box.
 - b. If psychotherapy notes are requested, no other information can be shared. A separate Authorization must be completed for additional information

Purpose for disclosing information:

1. Check the appropriate box.
2. If the purpose is not listed, check the "other" box and indicate the purpose in the space provided.

Expiration Date:

1. Unless otherwise indicated at the bottom of the form, the expiration date is one year from the date of the patient's signature or upon the occurrence **or** an event chosen by the individual.
 - a. If the patient chooses an event, list the event in the space provided.
 - b. If the patient chooses to make the expiration date longer than one year, indicate in the space provided at the bottom of the form.

Signature:

1. Obtain the signature of the patient or Legal Representative
2. If a Legal Representative signs the form, indicate the description of the Legal Representative's authority.

Date:

1. The date is the date the form is signed.