



**Authorization for Release of Personal Health Information (PHI)**

**Must Be Completed For All Authorizations:**

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand that treatment will not be withheld if I refuse to sign this authorization, unless the requester requires authorization prior to payment.

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Person/organization providing the information:

Person/organization receiving the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The purpose for this authorized release of information is: \_\_\_\_\_

At the request of the individual.

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked we can not release them.

\_\_\_\_\_ Drug Abuse (if any)

\_\_\_\_\_ Substance Abuse (if any)

\_\_\_\_\_ Psychological or Psychiatric conditions (if any)

\_\_\_\_\_ AIDS/HIV (if any)

**Please release the following records:**

\_\_\_\_\_ All records generated in this office

\_\_\_\_\_ Other: \_\_\_\_\_

(Specific dates of treatment or specific description or information requested)

Are you leaving our practice? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

**Must be Completed For All Authorizations:**

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that by notifying the practice in writing, I may revoke this authorization at any time. However, if I do so, there will be no effect upon records released prior to the date the written revocation was received.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient's Representative