Authorization/Release for Protected Health Information (PHI)

Patient Legal Name Date of Birth

Address Phone#

City State Zip Code

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above.

Requested Delivery Method: 0 Mail 0 Pick Up 0Email/Fax: ___________________________

Facility/Doctors Name

From: ________________________________ To: __________________________________

Name: ________________________________ Name: _______________________________

Address: ______________________________ Address: _____________________________

______________________________ ______________________________

Phone# _______________________________ Phone# ______________________________

Fax# __________________________________ Fax# _________________________________

Reason for Transfer:______________________________________

Type of Access Requested: Specific Date Range Requested:

Dates and Type of information to disclose:

- 2 years prior from last date seen
- Dates Other: _______________________________________
- Immunizations
- Specific Information Requested: ________________________

● I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

● I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

● The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

● I understand that the term Complete Chart for release of Protected Health Information mean that only Records generated by this facility will be released.

● I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Parent/Legal Guardian Date