Optimal Care & Wellness

74 W 2nd St, Yuma AZ 85364 – Phone (928) 257-1223 – Fax (928) 267-4091

Authorization to Release Protected Health Information

I authorize _____ to disclose protected health information (PHI) from the health records of:

Patient name: _____

Date of birth: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Date of request: _____

I authorize the release of PHI for service from _____(date) to _____ (date).

Release to:

☐ **Self** ☐ **Spouse (name): _____**

☐ **Provider (name):_____**

☐ **Other (name): _____**

Mailing address: _____City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Purpose for disclosure: _____

How would you like to receive the information: ☐ Email: _____ ☐ Mail

☐ Fax ☐ Pick up

Specific description of PHI to be disclosed:

☐ Office visit- Date: _____ ☐ Complete health record- Starting date: _____

☐ Diagnostic images- Date: _____ ☐ Lab report- Date: _____

☐ Billing records: _____ ☐ Other: _____

I authorize the provider to use or disclose information related to the following:

☐ Alcohol and/or drug abuse treatment, initial _____

☐ AIDS/HIV and other communicable diseases, initial _____

☐ Behavioral health care/psychiatric care/mental health information, initial_____

I understand that the failure to sign this authorization or the cancellation of this authorization will not prevent me from receiving any treatment I am entitled to receive, provided this information is not required to determine if I am eligible to receive the treatment or to pay for the services I receive.

This authorization is subject to revocation at any time in writing to Optimal Care and Wellness at the address located at the top of this form, except to the extent that entity, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this authorization will terminate in one year or upon the following date: _____

I understand that, if this information is disclosed to a third-party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of patient **Date**

_____ _____

Signature of legal healthcare decision maker **Relationship to patient**