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# Request for Release of Protected Health Information (PHI)

Patient's Name (Please Print) | Date of Birth | Social Security Number

Street Address | City | State | Zip

**Do hereby authorize the use and/or disclosure of my protected health information (PHI)**

AUTHORIZED ENTITY

I request to have information released ☐ **from** or ☐ **to** the following entity: (check one)

Name

Street Address | City | State | Zip

Phone Number | Fax Number

AUTHORIZED PROTECTED HEALTH INFORMATION

☐ Complete Record
☐ Records of care from _____ to _____
☐ Records of care regarding condition(s): _____
☐ Confer with designated person(s) orally about information in my medical record
☐ Other/Specify: _____

I understand that the release of medical records may involve making available to myself or to the other information of a personal nature. Issues with regard to personal use of cigarettes, alcohol, and other drugs, as well as possible exposure to infections disease may be part of the medical record.

HIV/AIDS: I Consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records ☐ YES ☐ NO Initials: _____

Purpose of Disclosure: ☐ Medical Care ☐ Employer ☐ Attorney ☐ Insurance ☐ Other: _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA Privacy regulations. I herby acknowledge that this consent is truly voluntary and valid until revoked, and that I may revoke this consent at any time; In writing, except to the extent that action basd on this consent has been taken. I further understand that this authorization will expire in 180 days from the signature date unless specified otherwise. _____(expiration date).

Signature of Patient or Legal Guardian | Date | Signature of Witness | Date