AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Information			
Last Name:	First Name:	MI:	DOB:

Choose to disclose the following PHI

☐ All PHI (Please check box below to include other sensitive PHI)

- ☐ HIV/AIDS Information
- ☐ Substance Abuse Information

☐ No PHI

☐ Select PHI as listed below:

- ☐ Billing information
- ☐ Medical Reports/Updates
- ☐ Lab Results
- ☐ HIV/AIDS Information
- ☐ Substance Abuse Information
- ☐ Medication Information
- ☐ Scheduling Information
- ☐ Other:______________________________

Party to Receive Information

☐ **None**

(Check if you decline to authorize anyone to receive PHI)

Last Name:	First Name:	Relationship:
Last Name:	First Name:	Relationship:
Last Name:	First Name:	Relationship: