HILLSIDE MEDICAL GROUP

AUTHORIZATION FORM FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH
PATIENT ADDRESS	PHONE NUMBER
OTHER NAMES USED	
NAME OF GUARDIAN OR LEGAL REPRESENTATIVE	

PERSON/FACILITY/ORGANIZATION AUTHORIZED TO RELEASE INFORMATION

PERSON/FACILITY/ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION	
ADDRESS	
PHONE NUMBER	FAX NUMBER

THE FOLLOWING HEALTH INFORMATION THAT RELATES TO SERVICES BEGINNING ON _____TO _____ MAY BE RELEASED:

COMPLETE CHART ☐ VISIT NOTES ☐ PATIENT SUMMARY ☐

LAB RESULTS ☐ XRAY RESULTS ☐ ITEMIZED BILL ☐

OTHER ☐ _____

REASON FOR DISCLOSURE: CONTINUUM OF PATIENT CARE ☐ TRANSFER OF PATIENT CARE ☐ PERSONAL ☐

THIS AUTHORIZATION IS VALID FOR _____ FOLLOWING THE DATE OF MY SIGNATURE BELOW.

- ✓ I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization or my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- ✓ Unless otherwise revoked, this authorization shall remain in effect for one year from today's date or on the expiration date indicated above for records generated as a result of services occurring on or prior to this date.
- ✓ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment.
- ✓ I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially laws.

_____ _____

Signature of Patient or Legal Representative Date

Relationship to patient: _____

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