

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**Section A: This section must be completed for all Authorizations**

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)  
 Date: \_\_\_\_\_ Event: \_\_\_\_\_

If this authorization is for disclosure of genetic information, it will expire 60 days after the date it is signed.

Purpose of disclosure: \_\_\_\_\_

**Description of information to be used or disclosed**

Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.	Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/>	All PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Itemized bill:	
<input type="checkbox"/>	Admission form		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> UB-92:	
<input type="checkbox"/>	Dictation reports		<input type="checkbox"/> Rhythm Strips		<input type="checkbox"/> Other: Anesthesia Order	
<input type="checkbox"/>	Physician orders		<input type="checkbox"/> Nursing Information		<input type="checkbox"/> Other:	
<input type="checkbox"/>	Clinical Test		<input type="checkbox"/> Transfer forms			
<input type="checkbox"/>	Medication Sheets					

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ (Initial) If not applicable, check here:

If this authorization is for disclosure of genetic information, please describe: \_\_\_\_\_

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If this authorization is for genetic information, it is invalid if used for any purpose other than that specified above.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
7. I get a copy of this form after I sign it.

**Section B: Is the request of PHI for the purpose of marketing?**

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?  Yes  No

If yes, describe: \_\_\_\_\_

**Section C: Signatures**

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

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:	
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:	

FPO SIGNATURE: \_\_\_\_\_

DATE REVIEWED: \_\_\_\_\_