

**Authorization to Disclose Protected Health Information (PHI)**
**This request to RELEASE medical records will be returned if not completed in its entirety**

Patient Name: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB \_\_\_\_\_

**I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:**
**①** The type and amount of information to be used or disclosed is as follows

 Include dates where appropriate:  

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Entire Record, or: | <input type="checkbox"/> Medication List    | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Provider Notes     |
|   | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> X-Ray/Dexa Reports   | <input type="checkbox"/> Cardiology Reports |
|   | <input type="checkbox"/> Other _____        |   |   |

**②** Please initial for release of the following information even if you checked "Entire Record" above.

_____ HIV Information	_____ Psychiatric / Mental Health Information	_____ Addictive Behavior
_____ Genetic Test Results	_____ Child & Domestic Abuse History	
_____ Communicable and Sexually Transmitted Disease		

**NOTE:** INFORMATION PERTAINING TO SUBSTANCE ABUSE DIAGNOSIS OR TREATMENT REQUIRES COMPLETION OF THE CONSENT FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION UNDER 42 C.F.R. PART 2 – CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS.

**③** REASON FOR REQUEST: (PLEASE CHECK ONE)

- 
- Medical Care
- 
- Insurance
- 
- Personal
- 
- Attorney
- 
- Other \_\_\_\_\_

**④** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS

**⑤** THIS INFORMATION IS TO BE DISCLOSED TO  Requestor  the following individual or organization

_____ Name	_____ Phone number	_____ Fax number
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_____ Address	_____ City, State, Zip
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**⑥** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Privacy Notice.

**⑦** I wish to receive this information on  Paper  CD (as a PDF file)

 Signature of Patient: \_\_\_\_\_  
Date of Signature

 Signature of Parent, Guardian  
 or Personal Representative  
 (if necessary): \_\_\_\_\_  
 (If Personal Representative, attach supporting documentation) Date of Signature

 Routed to: \_\_\_\_\_  
 By: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Completed: \_\_\_Y\_\_\_N  
 Scanned by: (initial) \_\_\_\_\_  
 Photo ID checked by: \_\_\_\_\_

**NOTE:** There is a charge not to exceed \$25 for copies of records unless information is being disclosed to a medical facility. PLEASE ALLOW 7-10 BUSINESS DAYS from date of receipt by HIM Dept FOR PROCESSING. Phone: (702) 560-2880 M-F, 8am-5pm