Authorization for Release/ Request of Protected Health Information (PHI)

Please print all requested information to prevent delays in our response & provide completed form to your facility.

Patient Name:____

Last First MI Maiden or Other

Address:____

City:_________________________ST:__________Zip:_________

Date of Birth:_____-_____-_____ Phone: ________________________________

E-mail address: ____

I understand that this authorization will allow this provider organization and its affiliates to use or disclose my protected health information. **I understand that my medical record may contain sensitive information such as mental health, HIV, AIDS, substance abuse, sexual abuse and /or other related conditions**. I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an express and informed written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative of as provided by state or federal law.

I hereby give my permission to this provider organization or entities listed below to release information contained in my medical records to:

Name & address of person(s), organization, or agencies to which information is to be released.

Name & address of person(s), organization, or agencies to which information is to be released.

Purpose of this release request: ____

I authorize release/request of information covering treatment dates of: ___________________________

Information to be disclosed / released includes the following:

- ____ **Discharge Summary**
- ____ **Treatment Plans**
- ____ **Labs**
- _____ **Immunizations**
- _____ **Progress Reports/ Notes**
- _____ **Social Development History**
- _____ **X- Rays**
- _____ **Special Studies (EKG, Mammogram, etc.)**
- _____ **Psychological / psychiatric Evaluations**
- _____ **All of my medical records including sensitive information (such as mental health, HIV, health status, sexual abuse or substance abuse records)**
- _____ **other (describe)** ____

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Requested method for responding to this request:

- ❑ **Paper copy to be mailed by USPS to address indicated above.**
- ❑ **Call at telephone number __________________________ for pick up**
- ❑***Email sent encrypted to: ____**

***For security of your information, all emails are sent encrypted unless requested unencrypted with recognition of risk.**

- ❑****Email sent unencrypted to: ____**

**** I understand that records sent through unencrypted email pose a security risk but it is my requested method.**

I understand the following:

- **I may revoke this authorization at any time by providing written revocation to this facility.**
- **I understand that a revocation of this authorization will not apply to any actions taken or information released prior to my written revocation.**
- **I understand that authorizing the disclosure of this information is voluntary. I also understand that treatment, payment or eligibility for services is not based upon signature of this authorization.**
- **I understand that information used or disclosed prior to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal privacy laws.**
- **I understand that this provider organization will release only the minimum amount of information necessary to fulfill the request.**

____

SIGNATURE OF PATIENT **DATE**

OR

____ ____

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON **RELATIONSHIP TO PATIENT**

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FOR INTERNAL USE ONLY

Complete the sections below and place in patient record.

Notice of Decision is: ❑ **Approved and provided per request** ❑ **Denied for reason indicated below.**

- ❑ Information requested is not part of patient's designated record set.
- ❑ Information requested is not available to the patient for access as required by federal or state law.
- ❑ A physician has determined that access to information requested may endanger the life or physical safety of the individual or another person.
- ❑ Other:____

____

Staff Member who processed request **Title** **Date**