Authorization for Release of Protected Health Information

1. Date: _____ 2. Company: Choose an item.

2. Patient Name: _____

3. Patient Address: _____

4. DOB: _____ 4. Medical Record Number: _____

I authorize the release of my Protected Health Information to:

Person/Company Name: _____ Phone: _____

Address: _____

We will share ONLY the information chosen below.

□ Billing/Registration Records □ Treatment Records □ Substance Abuse Records □ HIV/AIDS Status

□ Sexually Transmitted Disease □ Other (please explain) _____

By signing this form, I authorize the disclosure of my Protected Health Information (PHI) for the following purpose:

□ At my request – no specific purpose required □ Specific Purpose: _____

This form will be valid for 1 year unless a shorter time period is listed below:

Request Valid From _____(mm/dd/yyyy) to _____(mm/dd/yyyy)

By signing below, I understand and agree:

□ I am entitled to a copy of this authorization.

□ Once released to a third party, my PHI may be shared with others. That means federal and state privacy laws no longer protect the use and disclosure of my PHI.

□ I may cancel this authorization at any time by submitting a *Revocation of Authorization for Release of Protected Health Information* form to the Privacy Officer at compliance@allianceptp.com .

□ If I choose to cancel this authorization, it will not affect disclosures made before submitting the revocation request.

□ My ability to receive health care services is not dependent upon me signing this form.

Signature of Patient / Patient Representative: _____

Date: _____

If this request is being signed by the patient's legal representative, you must provide legal documentation authorizing you to act on the patient's behalf (e.g. legal guardianship, power of attorney, personal representative).

If you are making this request on behalf of a minor child, we may require additional information before processing this request.

Please return this form to medrecs@allianceptp.com . You may also fax it to 616-356-5001 or return it to your local clinic.