



Medical Record Number: \_\_\_\_\_  
Account Number: \_\_\_\_\_

### RELEASE OF INFORMATION/PHI

All portions of this form **MUST** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be invalid.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Person to whom records are to be released: ☐ Self ☐ Physician ☐ Attorney ☐ Other: \_\_\_\_\_

Reason for Release: ☐ Personal ☐ Continuation of Care ☐ Other: \_\_\_\_\_

Dates of Service Requested: \_\_\_\_\_ to \_\_\_\_\_

Health Information that may be used/disclosed: *(Please check ALL that applies)*

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultations	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Radiology	<input type="checkbox"/> Labs	<input type="checkbox"/> EKG <input type="checkbox"/> Entire Record

Health Information identifies you (the Patient) by name, and includes other demographic information about you. Health Information may include but is not limited to: medical records, x-ray films, slides, tracings, strips, etc. (Specify by circling: CT MRI Other: \_\_\_\_\_)

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specific event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

☐ This authorization is valid greater/lesser than 60 days. Expiration date shall be: \_\_\_\_\_.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient/Authority to Act on Patient's Behalf \_\_\_\_\_ Interpreter, if utilized: \_\_\_\_\_

Witness Signature : \_\_\_\_\_

Person releasing records Initials: \_\_\_\_\_ Date Released: \_\_\_\_\_ Number of pages released: \_\_\_\_\_ Method: ☐ mail ☐ fax ☐ in-person