



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)

[] Discharge Summary	[] History & Physical	[] Consultations	[] Operative Report	[] Pathology Report	
[] Physician Orders	[] Progress Notes	[] Radiology	[] Labs	[] EKG	[] 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