Thriveworks

Patient Authorization for Disclosure of PHI (Protected Health Information)

I, (Name)_____, wish to obtain a copy of my medical record and/or information about my treatment, or have Protected Health Information (PHI) disclosed to a 3rd party.

My Social Security Number	My Date of Birth
My Telephone Number	Reason for Record/PHI Request

I am requesting the following:

Just Dates and Charges of Services	A Summary of my Sessions & Treatment
My Entire Clinical Record	Other (Explain)

I would like this information sent to:

Name	Address

Alternatively:

I give permission for Thriveworks to speak with (Name)_____ about my treatment. He/she can be reached at (Phone)_____. This permission excludes the following from discussion/release: (note any exclusions)_____.

Important Terms:

I understand that if I have any questions about my clinical records, or the content within, I can contact Thriveworks and someone will meet with me to discuss my records. **I understand** that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 & 164 and 42CFR Part 2 cannot be disclosed without my written consent unless otherwise provided for in the regulations. **I understand** that authorization is ongoing but that I may revoke this consent at anytime and that any notice to revoke consent must be in writing. **I understand** that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

Name: (Patient)_____

Signature: _____ Date: _____