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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

Printed Name: _____ DOB: _____

Address: _____ Phone: _____

_____ SSN: _____

Please circle purpose of request

CHANGING PHYSICIAN	RELOCATION	COPY FOR PERSONAL USE

Please Check One

SENDING RECORDS TO:	
OBTAINING RECORDS FROM:	

Physician/Facility Complete Name: _____

Address:_____City:_____State:_____Zip:_____

Phone:_____Fax:_____

Please Check Information to be obtained

COMPLETE HEALTH RECORD		PATHOLOGY RESULTS	
IMMUNIZATIONS ONLY		LAB RESULTS	
RADIOLOGY/IMAGING RESULTS		OTHER, PLEASE SPECIFY	

Patient or patient's representative must read and initial the following statements:

DRUG AND/OR ALCOHOL ABUSE, AND/OR PSYCHIATRIC, AND/OR HEPITITIS /HIV/AIDS RECORDS RELEASE

I understand the health record may include information related to sexually transmitted diseases, behavioral and mental health services, alcohol abuse, drug abuse or other sensitive information. Initial_____

TIME LIMIT AND RIGHT TO REVOKE AUTHORIZATION

I understand that this authorization will expire in 12 months unless otherwise specified. I understand that I may revoke this authorization. I must do so in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. Initial_____

Signature of Patient or Patient's Representative:_____Date:_____

Relationship to Patient:_____