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Authorization to Release Protected Health Information

HIPPA Compliant Request for Information

_____
Name of Patient | Street Address

_____
Phone Number | Fax Number | City | State | Zip Code

_____
Email Address (please be sure to print clearly) | Date of Birth (00/00/0000) | Last Four Digits of SSN

I hereby give the following person(s) or entity to release my protected Health Information (PHI):

Please choose the method of delivery by checking the preferred option and filling in the information where required. Be certain that information is accurate and complete. **Incomplete authorizations are invalid.**

_____ U.S. Mail to my personal address.
(*Records will be mailed to address listed above)*

_____ I prefer to pick up my records personally. Please call me when they are ready.
(Photo ID will be required for pick up)

____ Please send my records to the following

_____
Name of medical office/Company/Entity you want to receive the records.

_____
Street Address

_____
City | State | Zip Code

(___)_____(___)_____
Phone Number | Fax Number

The protected Health Information (PHI) I would like to have released is as follows:

___ Release an abstract of my PHI (two (2) year summary)

___ Release my entire chart (subject to state regulated per page fees)
(You will receive an invoice. Records are not released until invoice is paid in full)

___ I would like specific dates of service_____

Please provide the purpose of your request _____

This authorization shall expire ninety (90) days from the date of signature, or at the following event: _____

I am requesting my PHI to be disclosed for the following reason: _____

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the health care provider at which this authorization was executed. Such revocation will be effect upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request.
The recipient of this protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law. I understand that this authorization will expire in 90 days from the date of my signature. I hereby acknowledge that I have read and fully understand the above statements that apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative (attach proper document) Date