AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) & MEDICAL RECORDS to a THIRD PARTY

Date: _____ Name of patient making Request: _____

Name of Designated Party to receive records: _____

COMPLETE AS APPLICABLE:

1. Please send a copy of my records for the period from _____ [insert date] to _____ [insert date] (including information from other health-care providers that it may contain) to:

Name_____

Address _____

City _____ State _____Zip_____

The purpose of this Authorization is: _____

I understand that my records may be subject to re-disclosure by recipient(s) and will no longer be protected by the HIPAA Privacy Rules.

2. Please allow _____ to pick up a copy of my records (including information from other healthcare providers that it may contain).

☐ My entire Medical Record

☐ My recent Radiographs

☐ My recent Test Results

☐ Other _____

I specifically authorize this Healthcare Facility to disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of PHI, if it is included in the records described in paragraph 1, above (initial where appropriate):

☐ HIV records (including HIV test results) and sexually transmissible diseases

☐ Alcohol and substance abuse diagnosis and treatment records

☐ Psychotherapy records / this serves as my signature release under Federal law

☐ Other / Specify: _____

This Authorization permits our Facility to use or disclose your Protected Health Information for purposes other than your treatment, payment to our Facility or the health care operations of our Facility. You have the right to revoke this Authorization by providing our Facility with written notice of revocation. The revocation will be effective upon receipt, except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization.

Our Facility cannot require you to sign this Authorization as a condition to the provision of services.

This Authorization shall expire on _____, 20_____, or one year after its effective date, whichever is sooner or unless it is revoked prior to the expiration date.

By Patient: _____Date: _____(Print name and sign)

Or

By Patient's Representative: _____Date: _____