

Medical Record #: _____

AUTHORIZATION FOR USES & DISCLOSURES OF PATIENT HEALTH INFORMATION (PHI)

PATIENT INFORMATION

PATIENT NAME:			BIRTHDATE:	
PATIENT ADDRESS:				
PATIENT PHONE #:		REQUESTOR'S NAME :		

RECIPIENT INFORMATION

RECIPIENT'S NAME:					
RECIPIENT ADDRESS:					
CITY:		STATE:		ZIP:	
PHONE #:		FAX #:			

This Authorization will expire six (6) months after date of signature or as specified below:

Date: _____

Purpose of Disclosure: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

<input type="checkbox"/> Mammography <input type="checkbox"/> Reports <input type="checkbox"/> Films <input type="checkbox"/> Other: _____	<input type="checkbox"/> CT <input type="checkbox"/> Reports <input type="checkbox"/> CD <input type="checkbox"/> Films <input type="checkbox"/> Other: _____
<input type="checkbox"/> MRI <input type="checkbox"/> Reports <input type="checkbox"/> CD <input type="checkbox"/> Films <input type="checkbox"/> Other: _____	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Reports <input type="checkbox"/> Films <input type="checkbox"/> Other: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, HIV, psychiatric information. I understand that such information cannot be released without my specific consent, except under a Court Order. It is my intent that information released is prohibited for any other purpose than that which is stated above.

I understand that:

1. I may refuse to sign this authorization and that is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may not longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, if I ask for it.
6. I may be charged a \$15.00 administrative fee, plus \$.50/page if requesting all PHI in record.
7. I get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the Protected Health Information as stated.

Signature of Patient/Guardian/Patient Representative

Date

Print Name of Patient/Patient Representative

Relationship To Patient