



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____ DATE OF BIRTH: ___/___/_____
SOCIAL SECURITY #: _____ TODAY'S DATE: _____

I authorize _____, LLC to use or disclose (as applicable) the following medical information (legibly circle all that apply):

- | | | |
|------------------------------|-------------------------|-----------------------------|
| Consultation Reports | Progress Notes | Operative/Procedure Reports |
| History and Physical Reports | Images | Lab (s) Reports |
| Pathology Reports | Radiology Reports | Research Records |
| Mental Health Records | Substance Abuse Records | HIV Results/Testing |
| Other (specify) _____ | | |

Please indicate date range for treatment and release _____

*Note: Authorizing the release of one or more of these items may include records which did not originate with this office but have been incorporated into the patient record now in the possession of this office.

**May take up to 72 hours

The use of disclosure (as applicable) is for the purpose of:

- Continuing Medical Care
 - Insurance
 - Legal
 - Research
 - At the Request of the Patient
 - Other (specify): _____
-

Check one: I DO ___ I DO NOT ___ authorize you to leave messages for me which may contain PHI Message number _____

Check one: I DO ___ I DO NOT ___ authorize you to contact me at my email address Email address _____

I DO authorize you to share information with:
Name and relationship _____

- I understand that _____, LLC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form.
- I understand that I may revoke this authorization by sending a written request for revocation to this office.
- I understand that when information is disclosed on my behalf pursuant to this authorization for release, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.
- I understand that there may be a fee associated with the release of my medical information.
- I understand that this authorization will not expire unless I request a revocation in writing.

Signature of Patient

Date

Signature of Authorized Representative

Relationship to Patient (must provide legal authority)