Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Address: _____

Email: _____ Phone: _____

I request that _____ (Healthcare Facility) disclose my protected health information (PHI) to:

Recipient Name: _____

Address: _____

Phone: _____ Fax (healthcare provider only): _____

I authorize the following protected health information (PHI) to be released from my medical record:

- ☐ Complete Medical Record (all pages)
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s)
- ☐ Immunization Record
- ☐ Emergency Room Record
- ☐ Billing Record(s)
- ☐ Abstract/Summary (including history and physical, operative reports, consultations, discharge summaries, laboratory, radiology and other significant diagnostic study results)
- ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment alcohol or drug abuse.

If this information applies to you, please indicate if you would like this information released/obtained:

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Result	☐ Yes	☐ No	Dates: _____
Mental Health Records	☐ Yes	☐ No	Dates: _____
Psychotherapy Notes	☐ Yes	☐ No	Dates: _____
Genetic Records	☐ Yes	☐ No	Dates: _____

Covering the period of healthcare (specific dates):

From: _____ to: _____ **OR** ☐ All past, present, and future encounters

Purpose for requesting information:

☐ Personal ☐ Continuation of Care ☐ Insurance ☐ Legal

☐ Other: (Specify reason) _____

Disclosure format (Paper is default if not marked):

☐ US Mail ☐ Fax ☐ Electronic Format.

Please indicate preference: ☐ CD ☐ Flash drive

Cost for release of Protected Health Information:

☐ $_____

I understand that Prima Medical Foundation may use and disclose my protected health information to carry out treatment, payment, health care operations or as indicated within this authorization for release of PHI. Additional information regarding the uses and disclosures of PHI is described in the Notice of Privacy Practices. A patient has the right to review the Notice of Privacy Practices before signing this release. A patient has the right to request restrictions on the uses and disclosures of protected health information. However, the organization is not required to agree with the patient's request for restrictions. I may revoke this authorization for release of PHI in writing, at any time, except to the extent that action has already been taken. I understand that these records are protected under federal and state law and cannot be disclosed without my authorization unless otherwise provided by law. I understand that requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations. If I fail to specify an expiration date, this authorization will expire one year from today's date. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the organization, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

The attached medical information pertaining to the above named patient is confidential and legally privileged. The organization has provided it to the above named recipient as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law.

Today's Date	**Patient First and Last Name (Print)**
Patient Date of Birth	**Signature of Patient/Parent/Guardian**
Expiration Date	If patient is a minor, relationship to patient