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

I authorize:_____ **to disclose the following information from the health records of:**

Patient's Name:_____ **Date of Birth:**_____

Address:_____ **Phone #:**_____

SSN or MR #:_____

Covering the following Dates of Service: (DATES MUST BE PROVIDED)

From (date):_____ **To (date):**_____

Information to be disclosed: (Check ALL that apply)

- ☐ ***Complete Health Records**
- ☐ **Consultation**
- ☐ **Operative Report**
- ☐ **History & Physical**
- ☐ **All Cardiology data (EKG, Holter, Stress Test, HUTT, Cath Report, etc.**
- ☐ **Discharge Summary**
- ☐ **Laboratory Tests**
- ☐ **X-Ray Reports**
- ☐ **Progress Notes**
- ☐ **Other (Please Specify):**_____

***Reason for requesting complete health records:**_____

I understand that medical records may include information regarding a sexually transmitted disease, AIDS, HIV, behavioral or mental health services, and/or treatment for alcohol and drug abuse.

This information is to be disclosed to:_____
Phone:_____ **Fax:**_____

For the purpose of:

Evaluation, treatment and continuity of care ☐ **Transfer of Care** ☐ **Personal Reasons**

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and will not apply to information already released under this authorization. Expiration date of this authorization:

Date:_____ **Event or Condition:**_____
(no longer than 1 year from date of authorization)

I understand I have the right to restrict the use or disclosure of my protected health information. List restrictions (if any):

_____

_____

I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by privacy rules. I also understand that the degree of privacy can be modified with a facsimile transmission and that the Practice and Physician are not responsible for records once they have been transmitted.

☐ **I choose to have my records faxed** _____ **Initials**

_____ _____
Patient or Legal Representative (include relationship to patient) **Date**

_____
Witness:
Initiated: 06/17/09