Reiter, Hill, Johnson & Nevin

FORM 001: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FROM REITER, HILL, JOHNSON & NEVIN

Section A: This section must be completed for ALL Authorizations

Patient Name:	**Birth Date:**	**Social Security No.** ***(optional)*****:**

Provider's Name and Address: **Reiter, Hill, Johnson & Nevin** **407 N. Washington, St., Suite 105** **Falls Church, VA 22046** Phone: (703) 533-9211 Fax: (703) 533-9401	**Recipient's Name:**	
	Email:	**Fax:**
	Address 1:	
	Address 2:	
	City:	**State:** / **Zip:**

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: **Event:**

Purpose of Disclosure:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐All PHI in Medical Record		☐X-Ray Films		☐Notes from Other Providers	
☐Registration Sheet		☐Lab/Test Results		☐Disability/FMLA Forms	
☐Medical History Form		☐Operative Reports		☐Work/School Notes	
☐Medication Sheet		☐Pathology Reports		☐Itemized Bill	
☐Office Visit Notes		☐Other Hospital Information		☐Other:	
☐Nurse Notes		☐Physical Therapy Notes		☐Other:	

I understand that:

1. **Reiter, Hill, Johnson & Nevin** will not condition treatment on my providing this authorization, except in the case of my participation in research related treatment.
2. I may refuse to sign this authorization and that it is strictly voluntary.
3. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, by requesting it in writing. Under **Virginia** law this information will be provided to me within 15 days of my request.
4. I may revoke this authorization at any time by notifying **Reiter, Hill, Johnson & Nevin**'s Privacy Officer, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation.
5. If the requester or receiver is not a health plan, health care clearing house, or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I acknowledge that I have the right to a copy of this authorization after I have signed it.

Section B: Is the Request of the PHI for the purpose of marketing? Yes ☐ No ☐
If yes, the health care provider must complete Section B, otherwise skip to Section C.

Reiter, Hill, Johnson & Nevin will ☐ will not ☐ receive financial or in-kind compensation in exchange for using or disclosing this information.

Section C: Signatures

I have read the above and authorize Reiter, Hill, Johnson & Nevin to disclose the Protected Health Information as described on this form.

Signature of Patient or Patient's Representative	**Date:**

Relationship of Patient's Representative, if applicable:

The authority of the patient's representative (attach evidence of authority to this Authorization):