AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996

I authorize_____ to Release Medical Information*_____
Obtain Medical Information*_____
_____ (Check one)

*Specific information to be released: _____ or

*Dates of service from_____ to _____

Patient's Full Name_____
Last First Middle Initial

Date of Birth: _____ Social Security #: _____

Patient's Address: _____

Patient's Phone Number: _____

To/From: _____
(Physician/Institution/Agency)
_____
(Street Address)
_____
(City, State, Zip Code)
_____
(Telephone Number) (Fax Number)

I permit the release of all information indicated above including, if any, information concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV or other communicable diseases test results, and/or diagnosis and treatment.

I understand that this authorization will expire one (1) year from the date listed below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent.

I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

_____ _____
(Signature of Patient/Legal Guardian/Personal Representative) Date

_____ _____
Relationship to Patient Witness