Authorization to Release Protected Health Information

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By signing below, I authorize the above-named practice to use and/or disclose the following Protected Health Information (PHI): _____

_____
Describe the Protected Health Information you are authorizing to be used and/or disclosed

This information may be used and/or disclosed for the purpose of:

☐ Patient request ☐ Research
☐ New provider transfer ☐ Other: _____

If applicable, I authorize the practice named above to disclose this information to

_____

This authorization expires _____
Date or event upon which authorization expires

I understand that once the information is released, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying, in writing, the above-named practice. However, a revocation will not affect any actions taken by the above-named practice prior to its receipt of the revocation.

I understand that the practice will not condition treatment on whether I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, the practice will not provide the treatment if I am unwilling to sign this authorization form.
- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, the practice will not provide the treatment if I am unwilling to sign this authorization form.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

A COPY OF THIS SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT