Authorization for Release of Protected Health Information (PHI)

Type or print:

I hereby authorize _____ to release health records information on:
Name of provider

Patient Name _____ DOB _____

Address _____ Phone _____

City/State/Zip _____ SS# _____

For Healthcare Covering the Period(s) from _____ to _____

- May include other healthcare providers' records? ☐ Yes ☐ No
- May records be faxed or electronically transmitted? ☐ Yes ☐ No

This information is to be released to:

_____ _____/_____
Name of person/facility to receive information Telephone # Fax #

_____ _____
Address of person/facility to receive information City, State, Zip

Information to be disclosed: (Please initial on appropriate line.)
____Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
____Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records
____Billing Records
____Specific records: Laboratory Tests_____Progress Notes_____X-Ray Reports____Other_____
It is preferable to request patients and third parties to indicate what specific parts of the record need to be disclosed so as to meet the HIPAA Privacy Rule minimum necessary standard. If the patient authorizes his or her complete designated record set (medical record) to be released to a third party, a full copy needs to be provided as the patient authorized.

The purpose of this disclosure is for:
☐ Continuance of Medical Care ☐ Attorney ☐ Insurance
☐ Other _____

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve months (12) from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request. I understand that I may request a copy of the information to be disclosed.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that DNA cannot require me to sign this Authorization as a condition to providing services to me. I understand disclosure is voluntary. I understand that if I have any questions about this disclosure, I may contact my physician or DNA Privacy Officer.

_____ _____
Signature Date

_____
(Relationship or status if signed by anyone other than patient, parent or legal guardian, personal representative, etc)