Authorization For Disclosure of Protected Health Information

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Address:_____**Phone:**_____

You may disclose the following health care information (check ALL that apply):

- ☐ Current Medical Records information (clinic notes, radiology reports, MRI reports, operative notes, etc. for last date of service, including 12 months prior to last date of service)
- ☐ Health care information (notes/reports) in my medical record related to the following treatment or condition:_____
- ☐ Health care information in my medical record (notes/reports) for the date (s):_____
- ☐ X-ray images (on CD)
- ☐ MRI images (on CD)
- ☐ Billing information
- ☐ Other - specify information & date(s):_____
- ☐ All Medical Records information (clinic notes, radiology reports, MRI reports, operative notes, etc.)

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply)

- ☐ HIV (AIDS Virus)
- ☐ Sexually Transmitted diseases
- ☐ Psychiatric disorders / mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Reason(s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Other (specify)_____

This authorization expires: *(if disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*

- ☐ On date:_____
- ☐ When the following event occurs:_____

My Rights – I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider. If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed name if signed on behalf of patient **Relationship (parent, legal guardian, personal representative)**