Authorization for Release of Protected Health Information

Patient Name: _____ Chart Number: _____

Address: _____ Date Of Birth: _____

_____ SS Number: _____

I authorize my protected health information to be:

____ Released to: _____

Address/Phone/Fax: _____

____Obtained from: _____

Address/Phone/Fax: _____

Please specify information to be released / obtained: **Purpose of release:**

___ Complete Record	___ Op Notes	___ Continuing medical care
___ Last Visit	___ H&P	___ Released to patient
___OB Records	___ HIV / STD test(s)	___ Insurance coverage
___ Labs	___ Pap / Biopsy	___ Insurance reimbursement
___Mammogram	___ Consult	

I understand that my medical record may also include information on diagnosis / treatment related to psychiatric or psychological conditions, drug and / or alcohol abuse, acquired immune deficiency syndrome (AIDS), and / or HIV status. I understand and agree that the information, if and, pertaining to any such diagnosis / treatment described above may be released. I understand that my medical record may contain information from other health care providers, which has been filed with my medical record.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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