



**Authorization For Use or Disclosure of/Access to Protected Health Information**

I, \_\_\_\_\_, [Print Name of Individual (i.e., patient, resident or client)] hereby authorize \_\_\_\_\_ [Insert Facility/Clinic] to use and disclose the protected health information as described below for the following patient:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I authorize the following person(s) or organization to receive the information:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**The following individually identifiable health information may be used and/or disclosed:**

(Below are the most frequently requested documents. This does not constitute your entire medical record, which you have the right to request.\*)

Check (✓) all that apply:

- Abstract (Includes<sup>1</sup>)
- Discharge Summary /Final Diagnosis<sup>1</sup>
- History and Physical Records<sup>1</sup>
- Consultation Reports<sup>1</sup>
- Operations and Procedures<sup>1</sup>
- Results of Diagnostic Testing<sup>1</sup>
- Emergency Room Records
- Lab Reports
- Radiology (for example: X-Ray) Reports
- Other Diagnostic Reports
- Diagnostic Images (Prepped by Radiology Dept)
- Immunization (shot) Record
- Physical Therapy Notes
- Physician Notes
- Medication List
- Itemized Bill

Other\*: \_\_\_\_\_



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Dates of treatment to be released: From: \_\_\_\_\_ To: \_\_\_\_\_

Reason or purpose for the use and/or disclosure of the information:  
\_\_\_\_\_

I request the form of release of information be \_\_\_\_\_ Electronic (Portal) \_\_\_\_\_ Paper (U.S. Mail or pick up)  
\_\_\_\_\_ Other (USB, etc...\*\*) \_\_\_\_\_ Electronic (Secure Email)  
\*\*Device must be provided by the facility

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

**Prohibition on Conditioning of Authorization:** The healthcare provider will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

**Re-disclosure:** I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

**Expiration:** This authorization will expire 1 year from the date signed unless the facility receives a Revocation as outlined below.

**Revocation:** I understand that I may revoke this authorization at any time by notifying the facility in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of

Authorization form. I understand that if I revoke this authorization, it will not affect any actions that were taken before the revocation letter was received. I understand that the facility cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.



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**This Authorization is binding:** The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Facility's Notice of Privacy Practices.

I understand a fee may be charged for copies of my medical record.

*If this authorization is for marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of PHI. \_\_\_ Yes \_\_\_ No*

<b>SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE</b>	<b>DATE (Required)</b>
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Printed name of individual's personal representative, if applicable:	
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Rationale for serving as personal representative to the individual (e.g., parent, legal guardian):	
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(Please include supporting documentation such as Power of Attorney documents, or other documents establishing status as the personal representative, when applicable.)	