



**Request for Access to/Authorization for Use and Disclosure of Protected Health Information**

PATIENT NAME: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ MAIDEN OR OTHER NAME \_\_\_\_\_  
 FORMER NAME: \_\_\_\_\_ MEDICAL RECORD \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

**I hereby authorize:** \_\_\_\_\_ **to disclose my protected health information as indicated below to:**

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY, STATE & ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
 NAME: \_\_\_\_\_ Relationship \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY, STATE & ZIP \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Mail  Hold for pick up by: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

DATES: \_\_\_\_\_

- Discharge Summary \_\_\_\_\_
- History & Physical Exam \_\_\_\_\_
- Progress Notes \_\_\_\_\_
- Lab Reports \_\_\_\_\_
- X-Ray Reports \_\_\_\_\_
- Medication Records \_\_\_\_\_
- Detailed Bill \_\_\_\_\_
- Consult Notes \_\_\_\_\_
- Other (specify content and dates): \_\_\_\_\_

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health or behavioral health
- HIV related information (AIDS related testing)

\_\_\_\_\_

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE    DATE

**PURPOSE OF DISCLOSURE:**

- Changing Physicians  Consultation  Insurance/Workers' Compensation  School  Research  At request of individual
- Legal (specify): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- For personal access (specify):  Copy  Inspection  Summary

**ACKNOWLEDGEMENT OF UNDERSTANDING:**

Initial each line

- \_\_\_\_\_ I understand the expiration date of this authorization is  \_\_\_\_\_  at end of research study;  not applicable for ongoing research.  
 (Authorization will expire 90 days from date signed unless otherwise stated)
- \_\_\_\_\_ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- \_\_\_\_\_ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- \_\_\_\_\_ By authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- \_\_\_\_\_ I understand that if I am being requested to authorize a use or disclosure that I will get a copy of this form after I sign it upon request.
- \_\_\_\_\_ I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review of any denial of access other than those made in accordance with applicable law.
- \_\_\_\_\_ I understand that I may be required to pay the cost of preparing and mailing copies, supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations. The fee will not exceed current state limits.

Patient/

Legal Representative Signature: \_\_\_\_\_ DATE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Records Received by: \_\_\_\_\_ DATE: \_\_\_\_\_ ID VERIFIED: \_\_\_\_\_