



Personal Health Information (PHI) Release Authorization Form

(Please Print)

Patient Information	Name: _____ Date Of Birth: _____ Age: _____ SSN: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Mobile Phone: _____ Home Phone: _____ Is there another name that your chart could be listed under? _____ If yes, what is the name? _____
Healthcare Facility / Provider	Person/Organization: _____ Street Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
Recipient	Person/Organization: _____ Street Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
Information	Specific medical records to be released <input type="checkbox"/> Complete medical records including all office notes and lab results (Including records related to HIV, if applicable) <input type="checkbox"/> Lab reports dated _____ Specific type _____ <input type="checkbox"/> Medical records from _____ to _____ <input type="checkbox"/> Other (be specific) _____
Purpose of Release	<input type="checkbox"/> Out of town move <input type="checkbox"/> Consult / second opinion <input type="checkbox"/> Insurance change (new insurance company _____) <input type="checkbox"/> Transferring care to new physician (please tell us why) _____ <input type="checkbox"/> Legal <input type="checkbox"/> Personal <input type="checkbox"/> Other (be specific) _____
Authorization	I understand that this authorization will be effective for 12 months unless cancelled by me in writing and that my cancellation will take effect when the provider receives written notice. X _____ X _____ Patient Signature Date Authorization I authorize the above listed provider to release my PHI as I have indicated
Staff Use Only	Info Released By: _____ Date: _____