## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____

Printed Name of Patient (First, Middle, Last) Date of Birth

_____ _____

Previous Name (if Applicable) Social Security:

_____ _____

Telephone Number Email Address

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**REQUESTOR INFORMATION:**

Name: _____

Relationship to Patient: _____

Organization (if applicable): _____

Address: _____

Phone: _____

Email: _____

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**RECIPIENT OF RECORDS:**

**I authorize the release of medical information to:**

Name/Organization: _____

Address: _____

Email: _____

Fax: _____

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**PURPOSE OF DISCLOSURE:**

☐ Continuity of Care / New Provider ☐ Legal/Litigation Purposes

☐ Personal Copy / Review of Records ☐ Insurance / Claim Submission

/ Work-Related Documentation ☐ Other (please specify): _____

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**RECORDS REQUESTED:**

Please check all that apply:

☐ Medical Records (e.g., progress notes)

☐ Billing Records

☐ Other (please specify): _____

☐ Psychotherapy Notes (If yes, this must be authorized separately and cannot be combined. A separate authorization must be completed for other records)

**Dates of Service Requested:** From ____ / ____ / _____ to ____ / ____ / _____

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**DELIVERY METHOD (CHECK ONE):**

☐ Email

☐ Fax

☐ Portal (if available)

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**EMAIL DISCLOSURE ACKNOWLEDGEMENT:**

I understand that email may not be a fully secure method of communication and may carry risk of unauthorized access or misdelivery of my Protected Health Information (PHI. I voluntarily request delivery of records via email despite these risks.

☐ **I acknowledge the risks described above and consent to receive my records via email.**

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**AUTHORIZATION TERMS AND DISCLOSURES:**

**VOLUNTARY AUTHORIZATION:** I understand that completing this authorization form is voluntary. I realize that the disclosing organization will not condition my treatment on completing this form.

**EXPIRATION DATE:** This authorization will expire one (1) year from the date of signature.

**RIGHT TO REVOKE:** I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it.

**SCOPE OF AUTHORIZED DISCLOSURE** I understand this authorization permits disclosure only of the information described in this authorization.

**RE-DISCLOSURE:** I understand that once disclosed, the information may be re-disclosed by the recipient and may no longer be protected under HIPAA.

**SENSITIVE INFORMATION ACKNOWLEDGEMENT:** I understand that the records requested under this authorization may include sensitive health information, if contained in the selected records, including mental health information related to mental health conditions, substance use history, HIV/AIDS status, genetic information, and other protected health information.

I acknowledge and authorize the release of any such information that may be contained within the records selected above.

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**SIGNATURE:**

**I have read the above and authorize the disclosure of the protected health information as stated.**

**Date: _____**

**Signature of Patient or Legal Representative: _____**

**(REQUIRED: Attach copy of valid government-issued photo ID)**

**LEGAL REPRESENTATIVE (IF APPLICABLE):**

**Name/ Authority to Act on Behalf of Patient: _____**

**(REQUIRED: Attach supporting documentation if applicable)**

| **Internal Use Only:** |
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| **Request received by: _____** |
| **Date received: ____ / ____ / _____** |
| **Records released by: _____** |
| **Date released: ___ / ____ / _____** |
| **Method of release: _____** |
| **Fees charged (if applicable): _____** |
| **Notes / Comments: _____** |