# Authorization For Release Of Protected Health Information (PHI)

## SECTION A: This section must be completed for all Authorizations for Release or Right to Access

Patient Name: _____ DOB: _____ SSN: _____

Requestor's Name / Address / Phone No. (Who is receiving PHI):

_____

_____

_____

Recipient's Name / Address / Phone No. (Who receives this form)

_____

_____

_____

Patient Address: _____

This authorization will expire on the following Date: _____/_____/_____

Purpose of Disclosure: _____

## SECTION B: DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? ☐ **YES**, then this is the only item you may request on this authorization.

**YOU MUST SUBMIT** another authorization for other items below. ☐ **NO, then you may check as many items below as you need.**

| DESCRIPTION | DATE(S) | DESCRIPTION | DATE(S) | DESCRIPTION | DATE(S) |
|---|---|---|---|---|---|
| ☐ All PHI in Psychotherapy Medical Record | | ☐ Laboratory | | ☐ Demographics | |
| ☐ All PHI in Medical Record | | ☐ Imaging/Radiology | | ☐ Itemized Bill | |
| ☐ History & Physical | | ☐ Pathology | | ☐ Claim Form | |
| ☐ All Progress Notes | | ☐ Operative Notes | | ☐ Other: | |
| ☐ Discharge Summary | | | | | |

**I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV or AIDS results, testing or information. _____ (Initial)**

**I understand that:**

1. I may refuse to sign this authorization and that it is strictly voluntary
2. If I do not sign this form, my health care and the payment for my health care will not be affected
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it
6. I will receive a copy of this form after I sign it

## SECTION C: SIGNATURES

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

_____ _____

Signature of Patient/Guardian/Patient Representative DATE:

_____ _____

Print Name of Patient's Guardian/Representative Relationship to the Patient

Premier Radiology

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