

Authorization for Release of Protected Health Information (PHI)

I,

Type your name here

hereby authorize,

Name of person or facility which has information

**to release the
following
information**

Describe health information to be released

to

Name of person or facility to receive information

**Address, city,
state, zip code**

Address, city, state, zip code of recipient

Telephone:

Type telephone number here

Fax

Type fax number here

**For the following
purposes:**

Type the purpose(s) here

**This authori-
zation is in effect
until (date or
event), when it
expires:**

Type the date or event that ends the release

Respondent's Name:

I understand that by signing this authorization:

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.

I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.

I have the right to receive a copy of this authorization.

I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by patient

Date _____

Or signed by personal representative

Date _____

on behalf of

Name of patient

Respondent's Name:

IDENTIFYING INFORMATION

COPY OF IDENTIFICATION ATTACHED YES NO

Type

Number

**IF NO IDENTIFICATION IS ATTACHED, YOUR
SIGNATURE MUST BE NOTARIZED.**

Notarized by _____

On _____

Notary Public Number _____

PERSONAL REPRESENTATIVE INFORMATION

WHAT LEGAL AUTHORITY DO
YOU HAVE TO MAKE MEDICAL
DECISIONS FOR THE PATIENT?

Parent

Guardian

Medical power of attorney

Conservator

Executor of will

Other (explain below)

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO
VERIFY THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN,
EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-
MAKING AUTHORITY FOR THE INDIVIDUAL.