**AUTHORIZATION FOR THE RELEASE**

**OF PROTECTED HEALTH INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request access to requested health information below from (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to (date) \_\_\_\_\_\_\_\_\_\_\_\_\_ .

|  |  |  |  |
| --- | --- | --- | --- |
| * Progress Notes | * Patient Plan | * Immunizations | * Physical Form |
| * Operative report | * Radiology reports | * Lab reports | * Other: |

Reason for request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Information from** | **Information to** |
| Name | Name |
| Address | Address |
| Phone | Phone |
| Fax | Fax |

I understand that my medical records or the record of the patient for whom I am signing may include alcohol abuse, psychiatric records, or HIV/AIDS testing and treatment and are covered by federal regulations and cannot be disclosed without my written consent unless provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event this consent will expire on \_\_\_\_\_\_\_\_\_\_\_\_ or no longer than one year from the date the authorization is signed. Dr. Burk is hereby released from legal liability or responsibility for the release of records to the extent indicated and authorized herein. Dr. Burk may not condition my treatment on my provision of this authorization. A photocopy or fax of this authorization is as valid as the original.

I understand that once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the information may not be protected by federal regulations.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_