AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the disclosure of my protected health information only as described below:

___Consultations	___Radiology Reports	___Surgical Reports
___Lab/Pathology Reports	___Physical Therapy Notes	___Outpatient Progress Notes
___Other	___Other	___**All Records**

I authorize the following person(s) to **make** disclosure of my protected health information:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

I authorize the following person(s) to **receive** and use my protected health information:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

I understand if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and will no longer be protected.

I understand I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware my revocation is not effective to the extent the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand authorizing disclosure of this health information is voluntary, and a fee may be charged for the handling and reproduction of said health information. I also understand original X-Rays will not be released and must remain a permanent part of my medical chart; however, a quality digital image will be made available upon request.

This authorization shall expire six (6) months from date signed.

My protected health information will be used or disclosed upon my request for the sole purpose of consultation to facilitate treatment and diagnosis.

_____ OR _____

Patient's Signature **Authorized Representative's Signature**

_____ _____

Patient's Name **Printed Name**

_____ _____

Patient's Date of Birth **Relationship to Patient**

_____ _____

_____ _____

Patient's Address **Address**

_____ _____

Date **Telephone Number**

_____

Date

Rev 1/2/2019