



AUTHORIZATION / RELEASE FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT LEGAL NAME _____ BIRTH DATE _____

SOCIAL SECURITY NO. _____ TELEPHONE NO. _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

FOR DISCLOSURE ONLY

I HEREBY AUTHORIZE _____
Practice name or physician

TO DISCLOSE MEDICAL RECORD INFORMATION AND/OR PROTECTED HEALTH INFORMATION OF THE PATIENT LISTED ABOVE TO:

Name/Title

Address

Purpose: _____

For treatment date(s) (if applicable): _____

TYPE OF ACCESS REQUESTED:

Copies of the record
Inspection of the record

Entire Record
History and Physical
Consult Report
Rehabilitation Services
Test Results

Office Notes
Billing Records
Internal Marketing
Other _____

Expiration: This Authorization shall expire upon (check one):

Fulfillment of this request (according to HIPAA or state regulations, whichever is shorter)

Date _____



I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

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

Date	Signature of Patient/Parent/Patient Representative	Relationship to pt
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Address and telephone number of requestor (if different from patient information)

Authorization #2
Effective Date 04/14/2003