AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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I authorize ____
(Providers Name, Practice Name or Hospital we are requesting records from)
to disclose protected health information ("PHI") from the health records.

Patient name: ______________________________________**DOB** _________________________

Patient Address____

Patient Phone number: ____

I authorize PHI from _____________________ (date) to ____________________(date) to be disclosed to:

Requesting Records from____

Address: ____

Office Phone: _____________________________ Office Fax:________________________________

Specific description of the information to be disclosed:
_____ Progress Notes
_____ Operative Reports
_____ X-Ray/Ultrasound Reports
_____ Lab Tests
_____ Other ____

Specific description of the purpose of the disclosure:
_____ Continued Patient Care
_____ Other ____
_____ The disclosure is at my (the patient's) request. (Additional fees may apply for Printed copies.)

I understand the matters discussed on this form. I release the provider, its employees, officers, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

___________________________________ ______________________________
Signature of Patient Date

___________________________________ ______________________________
Signature of Legal Representative Relationship to Patient