



Medical Records Release and Authorization For Use or Disclosure of Protected Health Information (PHI)

Please complete the following information:

Patient Name: _____
Address: _____
Phone: _____
SSN or Driver's License #: _____
Email address: _____
Fax number: _____

The information may be used/ disclosed for each of the following purposes:

- At my request (only the patient can check this box) Employment purposes
 For my health care Other: _____
 For payment/insurance
 Disability

Please Check Specific Information Requested

Initial Evaluation	
Intake Forms	
Daily Treatment Notes	
Discharge Summary	
Scripts	
Progress Report	
Re-evaluation	

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDS virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

Signature of patient (or personal representative/guardian)

Date

Printed Name of patient representative/guardian

Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare, executor)

A copy of this signed authorization must be given to the individual.