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Authorization for Use and Disclosure of Protected Health Information

Patient Information	Name:	Date of Birth:
	Address:	Cell Phone: Home Phone: Work Phone:
	Primary Care Physician:	Social Security Number:
Releasing Health Care Provider Who has the information you want released?	Name:	
	Address:	Phone:
		Fax:
Receiving Party Where do you want the information sent? Who may have the information?	Name:	
	Address:	Phone:
		Fax:
Information to be Released What information do you want to send? Check all the boxes that apply.	☐ All records for dates of service _____ to _____. ☐ Only the records checked below: ☐ Office Notes ☐ Operative Reports ☐ Billing Records ☐ Pharmacy/Prescription Records ☐ Hospital Notes ☐ Radiology Reports ☐ Lab/Pathology Reports ☐ Other:	
Release Method/Format:	☐ Paper ☐ CD ☐ Fax	
Purpose of Release Why is the information needed?	☐ Continuing Care ☐ Transferring to a New PCP ☐ Disability Determination ☐ Insurance Purpose ☐ Litigation/Legal ☐ Personal Use/Review ☐ Other:	
Request Expiration	This authorization lasts for one year after the date that you sign it unless you enter a different date of expiration here: ____/____/_____.	

I understand that by signing below, I am authorizing Family Physicians of Evans to use or disclose information about myself (or another person for whom I have the authority to sign) that is protected under federal law, for the sole purpose and time period described above. Subject to certain exceptions, I have the right to inspect and copy the protected health information. This information is protected under federal law, and I have the right to revoke this authorization in writing. Any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. Family Physicians of Evans will not condition treatment based on my authorization. I have the right to refuse to sign this authorization.

Signature of Patient (or Patient Representative) Date

Printed Name of Patient (or Patient Representative) Representative's Relationship to Patient