# Authorization for Disclosure of Protected Health Information

Patient Name: ________________________________________________ Date of Birth:______________

Address:_____________________________________________________ Phone:____________________

**You may disclose the following health care information (check ALL that apply):**

- ☐ Current Medical Records information (clinic notes, radiology reports, MRI reports, operative notes, etc. for last date of service, including 12 months prior to last date of service)
- ☐ Health care information (notes/reports) in my medical record related to the following treatment or condition:_____ ________________________________________________
- ☐ Health care information in my medical record (notes/reports) for the date(s): __________________________
- ☐ Imaging (MRI, CT, X-ray etc.) ☐ **ON CD** ☒ **__SEND PAPER REPORTS ONLY**
- ☐ Billing information
- ☐ Other - specify information & date(s):_________________________________________

**You may use or disclose health care information regarding testing, diagnosis, and treatment for (initial all that apply)**

___ HIV (AIDS Virus)

___Psychiatric disorders / mental health

___Sexually transmitted diseases

___Drugs and/or alcohol use

This information has been disclosed to you from records protected under Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**You may disclose this healthcare information TO:**

Name:_________________________________

Address:_______________________________

City:______________State:_____ Zip:________

Phone:_________________________

Fax:___________________________

**This healthcare information is being requested FROM:**

Name:_________________________________

Address:_______________________________

City:______________State:_____ Zip:________

Phone:_________________________

Fax:___________________________

**Reason(s) for this authorization (check all that apply)**:

- ☐ At my request
- ☐ Other (specify)______________________________________________________________

**This authorization expires***: (if disclosure is to a financial institution or employer of the patient for purposes other than payment, then as to those disclosures this authorization expires 90 days after signed, unless renewed.)*

- ☐ On date:________________
- ☐ When the following event occurs:_____________________________________________

**My Rights –** I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider. If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

_________________________________________

**Patient or legally authorized individual signature**

_________________________________________

**Date**

_________________________________________

**Printed name if signed on behalf of patient**

_________________________________________

**Relationship (Parent, legal guardian, personal representative)**