HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Names Used** _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

2. Be sent to the following person / entity at the address listed below:

   Name _____

   Address _____ Telephone _____

   City, State, Zip Code _____ Fax or Email Address for Delivery _____

3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization Records Only
   ☐ Service Dates Only: _____ to _____ ☐ Specific Information Only:

   _____

NOTES

The reason for this authorization is: (check one)

☐ Continued Patient Care ☐Attorney/Legal ☐Insurance ☐ Social Service/Disability ☐Personal

☐ Other: _____

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ _____ _____

Signature of Patient **Date of Patient's Signature** **Patient's Date of Birth**

_____ _____ _____

If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate **Date of Legal Guardian's/Personal Representative's Signature** **Description of Authority to Act for the Individual**