



Authorization to Disclose Protected Health Information

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This form is for all record requests.

RELEASE INFORMATION FROM:

Specify Provider/Organization Name and Facility Address

Organization Name: _____

Address: _____

RELEASE INFORMATION TO:

Specify Provider/Organization Name and Facility Address

Organization Name: _____

Address: _____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____ **ACCOUNT #** _____

DATE OF BIRTH ____/____/____ **SSN #** _____

ADDRESS _____

Mailing Address, City, State, Zip

Covering the period(s) of health care:

FROM (Date) ____/____/____ **TO** (Date) ____/____/____

1. Information authorized for disclosure, if included in my records:

- Complete Health Record
- Visit/Discharge Summary
- Clinical Documentation of Physical
- Documentation of Consultation
- Immunization Records
- Progress Reports
- Radiology and Diagnostic Imaging Reports
- Photographs, Videos, Digital or Other Images
- Pathology Reports
- Laboratory tests *(please specify)* _____

- Other *(please specify)* _____
