Authorization/Release for Protected Health Information (PHI)

Patient Legal Name _____ Date of Birth _____ SSN _____

Address _____ Phone# _____

City _____ State _____ Zip Code _____

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above

Requested Delivery Method: ☐ *Mail* ☐*Pick up*

FROM: Facility/Doctor name
Name/Title_____

Address _____

_____

Phone #_____

(MUST BE COMPLETE ADDRESS)
TO:
Name/Title_____

Address _____

_____

Phone #_____

Fax #_____

Reason to Release Protected Health Information_____

Type of Access Requested: Specific Date Range Requested:_____

o Copies of Records	o Entire Record o Pertinent info only o ER Records o History & Physical o Consult Report o Operative Report o Rehabilitation Services	o Lab o Imaging/Radiology o Cardiac Studies o Demographics o Nursing Notes o Medication Record	o Progress Notes o Physicians Orders o Billing Records o Immunizations o Other

Expiration: This authorization shall expire upon (check one):

- o Fulfillment of this request
- o Date_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
I understand that there may be a fee involved with the fulfillment of this request. **See fee schedule below.**
I understand that the term Complete Chart for release of Protected Health Information mean that **only records generated by this facility will be released.**
I have read the above and authorize the disclosure of the protected health information.
For closed clinics there will always be a fee for copying of records.

Signature of Patient/Parent/LegalGuardian_____ Date_____

Fee Schedule

Fees for duplication of Protected Heath Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed $14.00 for the first ten or fewer pages, $.50 per page for pages 11-40, and $.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any may be charged.

*** To ensure timely processing of medical records, please fill authorization out completely.**

Credit Card Payment Slip

Date Received_____ **Initials of person taking CC pmt**_____

Payment Information

Invoice #_____ Amount $_____

Credit Card information

☐ Visa ☐ Master Card

CC# __ __ __ __ -__ __ __ __ -__ __ __ __ -__ __ __ __ Exp __ __/__ __

Billing Zip Code for CC _____

Corporate Card?_____ If yes, please provide Customer Code_____

Contact Name_____ Contact Phone#_____

Would you like a receipt mailed to you?

☐Yes ☐ No

Is the mailing address on the invoice where you would like the receipt to be mailed?_____, if no please provide address below

Mailing Address_____

_____

Printed Name on Credit Card_____