



# 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): \_\_\_\_\_
- X-ray images (on CD)
- MRI images (on CD)
- Billing information
- Other - specify information & date(s): \_\_\_\_\_
- All Medical Records information (clinic notes, radiology reports, MRI reports, operative notes, etc.)

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

- HIV (AIDS Virus)
- Sexually Transmitted diseases
- Psychiatric disorders / mental health
- Drug and/or alcohol use

**You may disclose this health care information to:**

Name (or title) and organization: \_\_\_\_\_

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)