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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification:

Printed Name _____ Birthdate ____/____/____
Address _____ Social Security ____-____-____
Phone number (____) ____-____

INFORMATION TO BE RELEASED BY:

INFORMATION TO BE RELEASED TO:

Physician or Facility _____
Street Address _____
City, State, Zip _____
Phone Number (____) ____-____
Fax (____) ____-____

Physician or Facility _____
Street Address _____
City, State, Zip _____
Phone Number (____) ____-____
Fax (____) ____-____

INFORMATION TO BE RELEASED – COVERING THE PERIODS OF HEALTH CARE:

From (date) ____/____/____ To (date) ____/____/____

Please check type of information to be released:

- Complete Health Record Pathology Report
Laboratory Test Results Complete Billing Record
Radiology Report EKG Report
Other (please specify)

Purpose of request:

- Treatment or Consultation At Patient's Request Billing Claims or Payment
Other (please specify)

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, which include the cost of supplies and labor; and postage related to the production of my information. First 25 pages, \$.50 per page, \$.25 each additional page. Payment must be made before records are copied.

Signature of Patient or Legal Guardian _____ Date ____/____/____

Printed Name of Patient _____

Witness _____

FORMS WILL BE READY IN FIVE (5) BUSINESS DAYS FROM DATE RECEIVED
IF THIS FORM IS NOT COMPLETELY FILLED OUT IT WILL CAUSE A DELAY