



## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name				Date of Birth
Patient Address	City	State	Zip Code	Telephone/Cell Phone

**REASON:**  Treatment (appointment date \_\_\_\_\_)  Personal  Legal  Insurance  Other (specify): \_\_\_\_\_

**DATES OF TREATMENT:** \_\_\_\_\_

**SPECIFY INFORMATION TO BE RELEASED:**  photocopies  CD

<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Emergency Report	<input type="checkbox"/> Anesthesia Reports	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> ED Summary Notes	<input type="checkbox"/> Discharge Summary	
<input type="checkbox"/> Radiology, Scans, MRI / MRA	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Discharge Instructions & Discharge Medications	
<input type="checkbox"/> EKGs, Cardiology Reports	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> PT	<input type="checkbox"/> OT <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Lymphedema Therapy
<input type="checkbox"/> Other ( Specify )			

**SENSITIVE INFORMATION FROM MY RECORD MAY BE RELEASED UNLESS CHECKED BELOW:**

<input type="checkbox"/> <b>Do not</b> release AIDS / HIV / STD information	<input type="checkbox"/> <b>Do not</b> release Mental Health information	<input type="checkbox"/> <b>Do not</b> release Drug / Alcohol / Substance Abuse information
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**INFORMATION SPECIFIED FOR RELEASE WILL BE RELEASED TO:**

Recipient's Name: \_\_\_\_\_

Recipient's Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release protected health information from my medical records as specified above. I understand that these records may include information related to AIDS, HIV, mental health, substance abuse and other sensitive information unless restricted above. I understand that this authorization is effective for a period of **90 days** from the date of signature, unless otherwise specified. No time frame may exceed one year from the date of the signature. Specify expiration date: \_\_\_\_\_. I understand that I have the right to revoke this authorization at any time by sending a written request to the facility that is responsible for maintaining these records. My decision to revoke this authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the authorization. Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/ person that receives the records may re-disclose the information, therefore (1) WMC and its staff / employees have no responsibility or liability as a result of a re-disclosure and (2) such information would no longer be protected by the Privacy Rule. WMC will not condition treatment, payment, enrollment or the eligibility for benefits on the completion of this authorization. A fax copy or a photocopy of this authorization is considered valid.

**If not the patient, please check designation below:**

<input type="checkbox"/> Parent or Legal Guardian	<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Next of Kin Of Deceased	<input type="checkbox"/> Executor of Estate
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Date \_\_\_\_\_ Signature of Patient or Legal Representative (Specify) \_\_\_\_\_

Date \_\_\_\_\_ Signature of Witness \_\_\_\_\_ If Verbal Authorization, Signature of 2nd Witness \_\_\_\_\_ Date \_\_\_\_\_

