AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Form 3002 (7/05)

I hereby authorize ________________________ to release information from the record of ____________________;
Name of Facility/Person Patient Name

_______________: ________________ as described below to ______________________________________
Birth Date SSN/MR# Name of Facility/Person

____
Facility/Person Address

Phone: ________________________________ Fax: ________________________________

Records are requested for the purpose of **(provide a detailed description):** ____________________________
____
____

The records to be released (identify all that apply) are **(please include approximate dates of service):**
___ Inpatient Records; Dates: _________________; ___ Emergency Room Records; Dates: _________________;
___ Outpatient Records; Dates: _______________; ___ Physician Office/Clinic; Dates: ____________________;

___ Medical History & Physical Exam ___ Progress Notes ___ Discharge Summary/Instructions
___ Laboratory Reports/Tests ___ Operative Report
___ Pathology ___ Medication Records ___ Other (specify): ____________________
___ Consults ___ Radiology ________________________________
___ Physician Orders ___ Immunization Records ________________________________

HIV, Behavioral Health and Drug and Alcohol treatment information contained in the parts of the record(s) indicated above will be released through this authorization, unless I request otherwise by checking here: ☐.

I understand the following:

- that my child's health record(s) will not be released or obtained unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information (Authorization).
- that the release of my child's health record(s) will be for the purpose stated on this form, and only those items checked off will be released
- that the health record(s) released by the disclosing party may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) the disclosing party and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule
- that this Authorization is in effect for a period of one year from the date of signature, unless a specific time frame is documented.
- that I have the right to revoke this Authorization form at any time by sending a written request to the disclosing party at the following address: ________________________________
- that my decision to revoke the Authorization does not apply to any release of my child's health record(s) that may have taken place prior to the date of my request to revoke the Authorization
- I understand that the disclosing party will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization or not.
- that I am entitled to a copy of this completed Authorization form

GENERAL AUTHORIZATION

____ ______________
Patient/Parent/Legal Guardian Signature Date

Name (please print or type):

____

If individual signing is not the patient, relationship to patient AND description of authority to act on behalf of patient:

____

____

ORAL AUTHORIZATION - NOT APPLICABLE TO HIV-RELATED INFORMATION

I witness that the person understood the nature of this release and freely gave his/her oral authorization (two witnesses are required).

____ ______________
Witness #1 Date

____ ______________
Witness #2 Date

Office Use Only ☐ **Copy provided to patient/parent/guardian**

BY - Signature:____

Name and title:____