



Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year, see page 2.

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Entity Requested to Release Information:

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me, to (please identify entity to receive PHI):

Entity Authorized to Receive Information:

Name (Entity or Individual): _____

Address: _____

Phone: _____ Fax: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:

Office notes Lab results X-rays OP Report

Hospital, nursing home, home health, hospice, and other physician records

Record of HIV and communicable disease testing

Record of mental health or substance abuse treatment

Financial history report (previous 3 years only).

Only send the following: _____

Purpose of disclosure (please describe the purpose of the disclosure or check patient request):

Patient request.

Other (please specify): _____.

Expirations or termination of authorization: This authorization will expire at the end of the calendar year in which it was signed, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our Administrator, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list date of expiration if earlier than end of calendar year): _____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Administrator.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the entities or person(s) you have listed to receive your protected health information (PHI). Therefore, your PHI disclosed under this authorization will no longer be the responsibility of the practice releasing the PHI and, depending upon the entity receiving it, may no longer be protected by the requirements of the Privacy Rule.

patient signature

date

Copies of signed authorizations are available upon request.