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**For Internal Use Only**

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Clinic / Office: \_\_\_\_\_ Number of Pages: \_\_\_\_\_

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## Instructions to Complete the Authorization to Release Protected Health Information

Please follow these instructions carefully when completing the authorization form. The form must be entirely completed. Failure to do so may result in a delay to process this request to release your medical record information. Please follow these steps and leave no box blank:

- A. Patient Name, Address, Date of Birth, Medical Record Number, Telephone Number and Social Security Number:** Print the name, address, date of birth, medical record number (if known), telephone number and the *last 4 digits* of the Social Security Number of the patient to whose protected health information ("medical record") is being released.
- B. Permission to Share:**
- i. Print the name, address, fax number and telephone number of the organization or individual from whom the medical record is requested.
  - ii. Print the name, address, fax number and telephone number of the organization or individual who will receive the medical record.
- C. Purpose of Release:** Check the box that best describes the purpose of your request. For example when information is needed for continuity of care or obtaining a second opinion, circle "Sharing with Other Health Care Provider".
- D. Treatment Dates:** Insert the treatment date or date range of the medical record you are requesting to be released.
- E. Documents to be Released:** Check each box YES or NO to identify the type of document you are requesting to be released. Please fill-in all boxes.
- F. Privileged or Specifically Protected Information:** Check each box YES or NO to indicate each type information you are authorizing for release. Please fill-in all boxes. If the patient had testing, diagnosis or treatment for any condition(s) as described under the "*specifically authorize*" section, it is required that you place your initials in front of the section(s) that describes the type of information to be released.
- G. Understanding/Agreement:** Please read the important information in this section.
- H. Expiration Date:** Insert the expiration date. If not specified; then this authorization will be valid for 12 months.
- I. Patient or Authorized Representative Signature:** The patient whose medical record is being released must sign and date the authorization OR the Authorized Representative of the patient to whom the medical record pertains must sign and date the authorization.

Please note: If the individual signing the authorization form is a Guardian, Executor of the Estate or Power of Attorney for the patient, that person must submit a copy of the appropriate legal document, which proves authority to act on behalf of the patient. This must accompany the authorization form.