

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No:
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1: 4403 West Tradewinds Avenue	
	Address 2:	
	City: Lauderdale by the Sea	State: FL Zip:33308

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: _____ Event: _____

Purpose of disclosure: **MEDICAL DOCUMENTATION**

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm Strips		<input type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing Information		<input type="checkbox"/> UB-92	
<input type="checkbox"/> Clinical Test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication Sheets		<input type="checkbox"/> ER Information		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial). If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

6. I get a copy of this form after I sign it. Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information Yes No
If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: _____ Date _____

Print Name of Patient/Plan Member's Representative: _____ Relationship to Patient/Plan Member _____