Appendix A
Sample Authorization Form

{Healthcare Facility Name} Patient Authorization for Disclosure of Health Information:

Patient Name :_____ Date of Birth: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Phone: _____

I **request that my protected health information (PHI) from {healthcare facility name} be disclosed to:**
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip:_____
E-mail Address: _____ Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s): Emergency Room Record Laboratory Report(s) Radiology Report(s) Pathology Report Immunization Record
Abstract/ Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations, and Test Results)
Test Result(s) of: _____
Radiology film/imaging studies/tracing/media
Itemized Billing Records
Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	□ Yes	□ No	Dates: _____
HIV Testing and Results	□ Yes	□ No	Dates: _____
Mental Health	□ Yes	□ No	Dates: _____
Psychotherapy Records	□ Yes	□ No	Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____ **OR**
All past, present and future encounters/visits

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other *(please specify other on line below):*
_____

Disclosure Format (Paper is default if not marked.): US Mail – paper format Fax (healthcare provider only)
E-mail (secure format) E-mail (unsecure format, i.e., Gmail, Yahoo) CD/Flash drive – secure format Other *(please specify):*
_____

By signing this authorization form, I understand that:
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: (ADDRESS). Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire *(insert time frame)* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- Marketing: Financial remuneration has been received by a third party for marketing purposes. *(Only required if applicable to the organization.)*
- Sale of PHI: Remuneration is received for disclosure of my health information. *(Only required if applicable to the organization.)*

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

(For Office Use Only)
Account Number: ***Medical Record Number:***