Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Expires one year from date of signature

Patient Name: _____ **Phone #:** _____

SSN (last 4 digits): _____ **Date of Birth:** _____

Entity Requested to Provide Information:

Individual / Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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 the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual / Entity Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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:

Check **only** those items of the record to be disclosed:

- ☐ Office Notes
- ☐ Operative Reports
- ☐ Lab results, Pathology Reports
- ☐ Radiology Reports
- ☐ Specific Dates Requested: _____
- ☐ Entire patient record
- ☐ Physical Therapy, Home Health/Hospice
- ☐ Other Physician Records
- ☐ Financial history report (previous 3 years only)
- ☐ Only Send the Following: _____

Body Part: right / left: _____

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

☐ Patient Request ☐ Other (please specify): _____

☐ Patient to **Pick up** the records ☐ PROS to **Mail** the records ☐ PROS to **Fax** the records

- **This Authorization will expire one year from your last signature below, unless you specify an earlier termination.** You must renew or submit a new authorization after the expiration date to continue the authorization.
  Please list the date of expiration if earlier than one year from the date of last signature: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of the healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient / Guardian or Representative Signature Date

You have the right to receive a copy of signed authorization upon request.

Date Sent _____ Date Faxed _____ Date Picked Up _____

Date Release Received _____ Date Records Ready _____ Initials _____