



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name _____

DOB _____ Phone number _____

1. Entity who is authorized to release Patient's information: (*PHMC or other entity in ownership of records*)

Name _____ Fax _____ Phone _____

2. Entity(ies) to whom the Patient's information may be disclosed (Where the records will be going.)

Name _____

Address _____

Phone _____ Fax _____

3. The specific information that should be disclosed:

_____ LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS _____ LAST 12 MONTHS OFFICE NOTES/LABS/X-RAYS

OTHER (BE SPECIFIC):

Pick up _____ Where? _____ Faxed _____ Mailed _____

4. The purpose for the disclosure is: _____

5. This authorization will expire on the following date or event: _____

If no expiration date or event is listed, the authorization will expire one year after the date of the authorization.

WE PROVIDE THE PAST TWO YEARS OF RECORDS TO OTHER PROVIDERS (with a note to call if they need more) IF A PATIENT WANTS ARCHIVED RECORDS SENT TO THEMSELVES OR ANOTHER PROVIDER, THERE WILL BE COPYING FEES APPLIED AS FOLLOWS: (1-50 PAGES \$15, 51-100 PAGES \$25, OVER 100 PAGES \$40) All records given directly to patients will be copied to a disc. Pre-payment is required.

Signed:

Patient

Date _____

Personal Representative Authority _____
(parent, guardian, etc.)