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PATIENT AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH CARE INFORMATION

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Social Security#:** _____
 _____ **Phone #:** _____

<input type="checkbox"/> I authorize Phillips Medical Group to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	OR	<input type="checkbox"/> I authorize Phillips Medical Group to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)
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Description of Information for disclosure/use:

- | | | |
|--|--|--|
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Lab work | <input type="checkbox"/> Immunization record |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Radiology results | <input type="checkbox"/> Other _____ |

Purpose of the use or disclosure:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Moving | <input type="checkbox"/> Physician request |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Changing doctor | <input type="checkbox"/> Specialty consult (i.e. Allergist/ENT) |
| <input type="checkbox"/> Other _____ | | |

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations. I understand that I may revoke this authorization at any time by sending a written request to the Practice Administrator. However, the revocation will not have any effect on any uses or disclosures the practice may have made before the revocation was received. I understand that unless I revoke the authorization earlier, this authorization will automatically expire one year after the date this authorization is signed. I understand that I may refuse to sign this authorization and that the practice will not condition treatment on whether or not I sign this authorization. I understand that a copy of this authorization will be provided upon patient request.

I certify that I am : _____ the patient _____ authorized representative

Signature: _____ **Date:** _____

If signature is not that of patient: Name: _____
 Address: _____
 Phone #: _____
 Relationship to patient: _____

Witness Signature: _____ **Date:** _____

Important Notice

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