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PATIENT AUTHORIZATION FOR DISCLOSURE

Patient Name: _____ Date of Birth: _____

I authorize Phillips Medical Group to obtain information from (Ex: former physician):

Name of Provider or Facility

City, State, and Zip Code

Phone Number and Fax Number

Description of Information for disclosure/use:

- Entire medical record
- Lab work
- Financial information
- Immunization record
- Radiology results
- Other _____

Purpose of the use or disclosure:

- Personal use
- Moving
- Specialty consult (i.e. Allergist/ENT)
- Insurance
- Changing doctor
- 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: _____ Relationship to patient: _____

Witness Signature: _____ Date: _____

Important Notice

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