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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

**Section A**: PHI to be used or disclosed, (must be completed for all authorizations)

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.**  I understand that this authorization is voluntary. I understand that the information used or disclosed may be subject to disclosure by the person or organization receiving the data and no longer protected by federal regulations.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the reason for request of PHI to be disclosed:

□ **Moving to new area**  □ **Change in insurance** □ **Provider leaving practice** □ **Specialist Requested**

**Dissatisfied with service of:** □ **Physician** □ **Staff** □ **Billing** □ **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TO:** I authorize the following Persons/Organizations **FROM:** I authorize the following Persons/Organizations

 to request my Private Health Information (PHI). to release my Private Health Information (PHI).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Specific description of information to be disclosed: **Dates of Service:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Copy of Complete Chart** □ **Copy of Progress Notes** □ **Copy of Lab Reports**  **□ Copy of X-Ray Reports**

□ **Immunization and Growth Chart** □ **History, Physical, Medication and Problem Lists**

□ **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Information regarding Mental Health and HIV/AIDS will not be disclosed unless specifically requested.

**Section B:** Must be completed only if a health plan or a health care provider has requested the authorization

What is the purpose of the use or disclosure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will the health plan or health care provider receive any financial or in-kind compensation in exchange for using or

disclosing the PHI described above? YES \_\_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_\_

I understand that I may see and copy the PHI described above and I will receive a copy of this form after I sign it. \_\_\_\_\_

Initials

**Section C:** Rights and Signature (must be completed for all authorizations)

I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that this authorization will expire on \_\_\_/\_\_\_/\_\_\_\_\_ or when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_occurs.

 DD/ MM/ YYYY Event

I understand that I may revoke this authorization at any time by notifying HealthPoint Family Care in writing, but if I do it will not have any affect on any actions taken before HealthPoint Family Care receives the revocation. The written revocation should be directed to the Compliance Officer at HealthPoint Family Care, 1401 Madison Avenue Covington, Kentucky 41011

I understand that **I MAY REFUSE TO SIGN THIS AUTHORIZATION**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s signature or patient’s legally authorized representative Date

Printed name if patient’s legally authorized representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How are you legally authorized to be the patient’s representative? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_