**AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION:**

Rise And Thrive Healthcare

Jessica K. Gutierrez, FNP-BC

(address)

(insert phone) (insert fax)

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I request that the protected health information (PHI) regarding the above named person be disclosed between:**

|  |  |
| --- | --- |
| From: | To: |
| Address: | Address: |
| City: | City: |
| State/Zip: | City/Zip: |
| Phone/Fax #: | Phone/Fax #: |

**I authorize the following PHI to be released from my medical record(s): Circle Below**

EMERGENCY ROOM RECORD LAB REPORTS RADIOLOGY REPORTS IMMUNIZATION REPORTS

ABSTRACT/SUMMARY (includes Discharge Summary, History & Physical, Operative Reports, Consults & Test Results)

Test Results Of:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Records:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

***State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information releases/obtained (which includes dates where appropriate):***

Alcohol, Drug, or Substance Abuse Records YES NO DATES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV Testing and Results YES NO DATES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health/Psychotherapy Records YES NO DATES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific period of healthcare dates: FROM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or ALL (past/present/future encounters)

Purpose for requesting information: (circle) Legal Insurance Personal Continuation of Care

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this authorization form, I understand that:**

\*Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

\*I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the office manager at the following address *(Insert address) .* Revocation will not apply to information that has already been disclosed in response to this authorization.

**\*Unless otherwise revoked, this authorization will expire in 30 days from the date signed.**

\*Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

\*Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

**Patient/Guardian Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Authorized Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient:** **Self Mom/Dad Legal Gardian Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**