

MEA Medical Clinics

Authorization for Release of Protected Health Information (PHI)

Patient's Name:	Birth Date:	Patient's Address: (city, state, zip)
Patient's Phone Number:	Patient's Email Address:	Last 4 Digits of Social Security Number:

Requester's Name:	Requestor's Relationship to Patient:
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Purpose of Disclosure

Medical Care
 Legal
 Insurance
 Personal
 Other

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

No, then you may check as many items below as you need.

Information to be disclosed:

<input type="checkbox"/> After Visit Summary (AVS)	<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Consultation	
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> EKG	<input type="checkbox"/> Other: _____	

Date of Service: _____ to _____ Date of Service: _____ to _____ Date of Service: _____ to _____

The following information will be released when included in the above unless you indicate otherwise:

<input type="checkbox"/> Do not release any AIDS or HIV test results	<input type="checkbox"/> Do not release any records of psychiatric care
<input type="checkbox"/> Do not release any records of alcohol/drug abuse	<input type="checkbox"/> Do not release records of genetic testing

Individual or Entity Authorized to DISCLOSE Information: Name: _____ Address: _____ City/State/Zip: _____ Phone Number: _____ Fax Number: _____	Individual or Entity Authorized to RECEIVE Information: Name: _____ Address: _____ City/State/Zip: _____ Phone Number: _____ Fax Number: _____
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1. I understand that this authorization is voluntary and that I may refuse to sign per the Health Insurance Portability and Accountability Act (HIPAA).
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I may get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Legal Representative:	Date:	Time:
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Print Name of Patient or Legal Representative:	Relationship to Patient or Legal Representative:
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This authorization shall expire on this expiration date: _____

**** If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed. ****