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Authorization for Release of Protected Health Information (PHI)

To be completed for all Authorizations		
Patient Name:	**Birth Date:**	**Social Security No. (last four only):**
Patient Home Phone #:	**Patient Cell Phone #:**	❑ **Male** ❑ **Female**
Provider's Name and Address:	**Recipient's Name:**	
	Address:	**Phone #:**
		Fax #:
Dates of Service: _____ **to** _____	**Purpose of disclosure:**	

Description of Information to be Disclosed

❑ **Consultation Reports**	❑ **Discharge Records**	❑ **Physician Orders**
❑ **Diagnostic Test Reports**	❑ **Office Notes**	❑ **Billing**
❑ **History & Physical**	❑ **Operative Reports**	❑ **PT/ST/OT Records**
		❑ **Physical Capacity Reports**

I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse (CFR 42).

I understand that:

- *I may refuse to sign this authorization and that it is strictly voluntary.*
- *My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.*
- *Records within the scope of this authorization (check marked above) may be disclosed pursuant to this authorization. Subsequent records will not be automatically released. If subsequent records within the scope of this authorization are requested, the patient or recipient is responsible for notifying the office of John F. Perry, MD of such request.*
- *I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.*
- *If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.*
- *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.*
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Signatures:

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

_____ _____

Signature of Patient (Parent/Guardian, if Patient is a Minor) **Date**

Witness Signature:	**Type of ID:**	**Date Released:**	**Amt. Charged:**
Date Copied:	**# Pages:**	**Copied by:**	

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