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INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a signed Authorization in order for your healthcare provider(s) to release medical information or records for reasons other than treatment, payment and healthcare operations. It is necessary to use this form because the law requires that specific information be provided before your records may be released.

In order to facilitate your request, please:

- Use one form for each medical provider from whom records are requested
- Complete the form in its entirety, following the directions below
- Sign and date the form

DIRECTIONS

Section A

Patient's Name:	The patient's full name - the person who received the medical service(s)
Date of Birth:	The patient's date of birth
Patient's Phone:	A phone number where the patient may be reached
Last 4 digits SSN:	The last 4 digits of the patient's social security number (optional)
Provider Name/Address:	The provider's name and address - *The provider is the hospital, doctor or other healthcare professional that you are asking to release the patient's information. Please provide a complete address.*
Recipient's Name/Address:	The name and address of the person that will be receiving the patient information. Please provide a complete address.
Recipient's Phone:	A phone number where the recipient of the patient information may be reached
Request Delivery:	The preferred method of delivery – *If information is requested by email/eDelivery, provide an email address in the space provided. If the facility is unable to provide electronic delivery, another delivery method will be provided (e.g. paper copy).*
Date/Event:	The date or event that the request will expire – *This should be a specific date or an event such as one year from the date of this authorization, upon the minor's age of majority, or upon termination of enrollment in the health plan. Provide either a date or an event, but not both.*
Purpose of Disclosure:	The reason for the request – *Reasons might include legal representation, continuity of care, research study, at request of the individual, personal, etc.*
Is this request for psychotherapy notes?	If the answer is yes, you must complete a separate authorization for release of any other information.
Description/Date(s):	Mark the box or boxes that best describe the type of health information being requested. Provide the date of service when the medical treatment was rendered.

- **Initial the line to acknowledge and consent to the release of information that may contain alcohol/drug abuse, psychiatric, HIV testing, HIV results or AIDS information.**
- **Please read items 1-6 carefully to ensure you understand the rights you have under this authorization.**

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Section B

Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? If the answer is No, skip to Section C. If the answer is Yes, the healthcare provider or health plan representative must complete Section B.

Section C

Signature of Patient/Patient's Representative: Patient signature is required unless the patient is a minor or a legal representative has been appointed.

Date: Date the form is signed

Printed Name of the Representative: Printed name of the individual who signed the authorization form

Relationship to Patient: If someone other than the patient signs the authorization form, description of the representative's authority to act on behalf of the patient must be provided. Examples are:

- *If the patient is an adult or emancipated minor, the personal representative is a person with legal authority to make healthcare decisions on behalf of the individual as granted in a Healthcare Power of Attorney, General Power of Attorney, or as a court-appointed legal guardian.* ***Supporting documentation required if not already on file at the facility.***
- *If the patient is a minor, the personal representative is a parent, guardian or other person acting as a parent to the minor, with the legal authority to make healthcare decision on behalf of the minor child.*
- *If the patient is deceased, the personal representative is a person with legal authority to act on behalf of the decedent or the estate, such as Executor of the Estate or next of kin.* ***Supporting documentation required if not already on file at the facility.***