



Authorization For Disclosure of Protected Health Information

PATIENT NAME: _____

DATE OF BIRTH: _____

Address: _____ Phone: _____

You may disclose the following health care information (check ALL that apply):

- ☐ Current Medical Records (last 12 months of clinic notes, radiology reports, MRI reports, operative notes, etc)
- ☐ All Medical Records information (clinic notes, radiology reports, MRI reports, operative notes, etc.)
- ☐ Health care information for only the specific condition of: _____
- ☐ Information in the date range of: _____
- ☐ Images for body part: _____
- ☐ Billing information

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply)

- ☐ HIV (AIDS Virus)
- ☐ Sexually Transmitted diseases
- ☐ Psychiatric disorders / mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release by: ☐ Fax ☐ Paper ☐ Pickup in office ☐ PDF file on CD ☐ Pickup in office
☐ Mail ☐ Mail

Reason(s) for this authorization (check all that apply):

- ☐ At my request
- ☐ Other (specify) _____

This authorization expires one year from date signed.

My Rights – I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. **I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider.** If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of patient

Relationship (parent, legal guardian, personal representative)