Mile High Psychiatry

HIPAA Privacy Release of Information Authorization Form

I hereby authorize and request to furnish the protected health information of:

Patient Name: _____ Patient DOB: _____

Social Security #:_____ Phone Number:_____

Address: _____ City: _____ State: _____

You may use or disclose the following health care information *(check all that apply)*:

❏ All my health information

❏ All my health information **except**:

- ❏ Mental Health Records
- ❏ Communicable Diseases (including HIV or AIDS)
- ❏ Alcohol/Drug abuse
- ❏ Lab Results

❏ Other: _____

I authorize for release of PHI covering the period of health care

❏ From (date) _____ to (date) _____

❏ All past, present, and future periods

Reason for this authorization:_____

This section is only applicable when records are being released from one organization/practice to another.

Release Records **FROM**:

Name:_____

Address:_____ City:_____ State: _____

Phone:_____ Fax:_____ Email: _____

Send Records **TO**:

Name:_____

Address:_____ City:_____ State: _____

Phone:_____ Fax:_____ Email: _____

I authorize disclosure of information regarding my billing, condition, treatment, and prognosis along with my PHI as I have selected above to the following individuals:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

I have carefully read and understood the above, have had any questions answered to my satisfaction, and do hereby voluntarily authorize disclosure of the above information or medical records of my conditions to those persons or organizations listed above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law.

_____	_____	_____
Patient or Legally Authorized Representative Signature	Relationship to patient	Date