

**AUTHORNIZATION for RELEASE of PROTECTED HEALTH INFORMATION (PHI)**

**In general, the HIPAA privacy ruled gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of their home. I wish to be contacted in the following manner (please check all that apply):**

**Cell Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Written Communication:**

**O.K. to mail to my home address \_\_\_\_\_\_**

**O.K. to mail to my work/office address \_\_\_\_\_\_**

**O.K. to fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby consent to the release of Protected Health Information (PHI) to the following individuals. I understand this authorization will be in effect until which time it is revoked. *Write NONE if no one to list.***

***Name* *Relationship***

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**