Standard Authorization to use or Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

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

Phone Number: _____ Social Security Number: _____

I authorize the release of my medical records by the organization or physician listed below:

Physician/Organization Name: _____

Physician/Organization Address: _____

Physician/Organization Phone: _____ Fax: _____

These records are to be sent to:

Physician/Organization Name: _____

Physician/Organization Address: _____

Physician/Organization Phone: _____ Fax: _____

Reason for Records Release: _____

___ Complete Medical Record: This would include Psychiatric (Mental Health), HIV/AIDS related diagnosis, evaluation information, and Substance Abuse (Drug and Alcohol) information.

___ Partial Medical Record -- Do <u>not</u> include the following areas of my records in this release:

- ___ Psychiatric (Mental Health) information
- ___ HIV and or Aids related Diagnosis, evaluation information
- ___ Substance Abuse (Drug or Alcohol) information

___ For these dates of service: _____

I understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by notifying in writing the company/individual from providing PHI identified in this authorization, but if I do revoke this authorization, it won't have any effect on any of Dr. Robert Pranger, Katie Weigel or Elizabeth Myhr's actions before they received the revocation.
- Information used as a result of this authorization may not be further disclosed without written authorization of the person whom it pertains.

I hereby authorize the use of disclosure of the Protected Health Information as described for the individual listed above. This authorization will expire in 1 year.

X _____ _____

Signature of Individual OR Individual's Personal Representative Date

Personal Representative Information (If the document was signed by a personal representative)

Name: _____ Date of Birth: _____

Address: _____ State: _____ Zip Code: _____

Phone Number: _____ Relationship to Patient: _____