Authorization to Release PHI (Protected Health Information) Access, Inspect, and/or Copy

Patient's Name: _____ Date of Birth: _____

Last 4 of SSN: _____

I request and authorize the above listed practice to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

Method of Delivery

☐ I would like my records mailed via USPS.

☐ I would like my records emailed to: _____

☐ I would like my records shared via verbal consult with _____

This authorization applies to health care information relating to the following treatment, condition, or date of treatment: _____

Or all health care information ☐ Or Other: _____

Once my practitioner gives out the information that I want released, I know that my practitioner has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____ _____

Signature of patient or patient's authorized representative Date Signed