**COMPOUND AUTHORIZATION TO RELEASE PHI**

­­­­­­­­­­­­Patient Name: Date of Birth: / /

Phone: Email:

**Patient authorizes to disclose the protected health**

Facility Name

**information (PHI) indicated below to:**

 Name of who will receive the PHI

Address: City:

State: Zip: Email\*:

Phone: Fax:

**PHI TO BE RELEASED:**

All PHI for treatment dates starting on \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ through \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

 All past, present, and future treatment visits (until revoked)

 Only the PHI checked below (specify dates if applicable)

|  |  |  |
| --- | --- | --- |
| **TYPE OF PHI** |  | **HOW TO DISCLOSE** |
| * Laboratory report(s)
 |  |  |
| * X-rays/imaging/film
 |  |  |
| * Immunization records
 |  |  |
| * Other test results:
 |  |  |
| * Medical records only
 |  |  |
| * Financial records only
 |  |  |
| * Photo taken by patient, legal guardian, or personal representative
 |  |  |
| * Photo taken by staff (e.g., pre/post procedure)
 |  |  |
| * Summary of record
 |  |  |
| * Appointment Reminders
 |  |  |
| * Breach notifications
 |  |  |
| * Other:
 |  |  |

Purpose of the requested release:

I understand information that is released may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

State and federal laws protect the following information. If applicable, indicate if you would like this information released/disclosed and include dates if necessary.

* Alcohol, Drug, or Substance Abuse Records
* HIV Testing and Results
* Mental Health
* Psychotherapy Notes\*

I have the right to revoke this authorization at any time in person or in writing.

I may inspect or copy the protected health information to be disclosed as described in this document.

Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

Information authorized to be used or disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.