

**ATTACHMENT B - AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**SUBJECT IDENTIFICATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

**AUTHORITY TO RELEASE PROTECTED HEALTH INFORMATION**

I hereby authorize \_\_\_\_\_ to release the information identified in this authorization form from the medical records of \_\_\_\_\_ and provide such information to \_\_\_\_\_.

**Information to Be Released – Covering the Periods of Health Care**

From (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

**Please check type of information to be released:**

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> Diagnosis & Treatment codes	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> History and Physical exam	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Laboratory Test Results	<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> X-Ray Films / Images
<input type="checkbox"/> Photographs, Videotapes	<input type="checkbox"/> Complete Billing Records	<input type="checkbox"/> Itemized Bill

Other (Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose of the Requested Disclosure of Protected Health Information**

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be “at the request of the individual”):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to release. **Check One:**  Yes  No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. **Check One:**  Yes  No

**Right to Revoke Authorization**

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to \_\_\_\_\_ at \_\_\_\_\_. Unless revoked, this authorization will expire on the following date, or after the following time period or event \_\_\_\_\_.

**Re-Disclosure**

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

**Signature of Subject or Personal Representative Who May Request Disclosure**

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed.

I hereby release and discharge \_\_\_\_\_ of any liability and the undersigned will hold \_\_\_\_\_ harmless for complying with this Authorization.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Description of relationship if not subject:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_