PLEASE COMPLETE THIS FORM IF: q We do not have records from your previous provider(s)

q You wish to have CPHC release your records to someone else

Authorization for Release of Personal Health Information (PHI)

Must Be Completed For All Authorizations:

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affect treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ Date of Birth: _____ SSN: _____

Person/organization providing the information: Person/organization receiving the information:

_____ _____

_____ _____

_____ _____

The purpose for this authorized release of information is:

_____

q At the request of the individual

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked they cannot be released.

q Drug Abuse q Substance Abuse q Psychological or Psychiatric conditions q AIDS/HIV

Please release the following records:

q All records generated in your office

q Other:_____

(Specific dates of treatment or specific description or information requested)

Are you leaving our practice? q Yes q No

If yes, please explain: _____

_____

Must be Completed For All Authorizations:

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations, and that the information may be re-disclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

_____ _____ _____

Signature of Patient or Patient's Representative Date Printed Name of Patient or Patient's Representative

Revocation of Authorization:

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s). I hereby revoke this authorization, effective____/____/____

_____ _____ _____

Patient Signature (Representative) Date Printed Name