Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for this provider and its affiliates to communicate PHI to the person(s) or organization listed below.

Individual information (person whose information will be released):

Patient name:_____Date of birth:_____/_____ /_____
Month Day Year

Address: _____
Street City State Zip

Patient Email address: _ _____
_____

Home Phone #: _____Cell Phone #: _____

I understand that this consent will allow this healthcare provider and its affiliates to use or disclose the protected health information* described below. (Please check only one box).

□ Full Disclosure: Any protected health information this provider and its affiliates collect and maintain, including mental health, HIV, sexually transmitted diseases, health status, alcohol and substance abuse treatment records, and genetic testing. This also includes information on health treatment programs, plan information and caregiver resources with the person being authorized.

□ Limited Disclosure: **Identify what protected health Information is to be excluded from any disclosure**. Such as a medical condition or treatment information or a specific date range of services:

_____

1) This information may be disclosed to, and used by, the following person(s) or organization(s) to assist me.

Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

2) This information may be disclosed to, and used by, the following person(s) or organization(s) to assist me.

Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

3) This information may be disclosed to, and used by, the following person(s) or organization(s) to assist me.

Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

This information is being disclosed to allow the person(s) or organization(s) above to assist me.

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to my provider.**
- **If I cancel the consent, it will not apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**

Individual or Legal Representative Signature_____Date:____/_____/ _____

□ Individual □ Legal Representative

Please note: Legal representatives must attach copies of authorization as required by law (e.g. healthcare power of attorney, healthcare surrogate, and living will or guardianship papers.

After you complete and sign the form, please return it to your primary care or specialist provider.

* Protected Health Information includes Medical, Dental, Pharmacy, Behavioral Health, Vision, and Long-Term Care.

This provider and its affiliates will follow the most stringent of all federal and state laws and regulations.