PHSC
Primary Health Services Center
"Champions in Health Care"

Authorization to Release or Obtain Health Information

Name of Requesting Party:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Social Security No.:
I Authorize: (indicate name of Person/Party being authorized):	Relationship to Patient:
Mailing Address:	City/State/Zip:

☐ **RELEASE** Information **TO** or ☐ **OBTAIN** Information **FROM**

(Place an "X" on the box if the information is being released OR requested.)

Name:	Mailing Addres :
Telephone Number:	City/State/Zip:

Purpose of Authorization is indicated in the box(es) below. Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for disclosure to a third party. ☐ Others (Specify)_____

I authorize the release of the following protected health information. *(Place an "X" in the box(es) that apply to the information you want released or you want to obtain.)*

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Hospital Records including Reports
☐ Prescriptions ☐ Immunizations ☐ Laboratory Reports
☐ X-ray Reports ☐ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

	☐ Alcoholism	☐ Drug Abuse	☐ Mental Health	☐ Vocational Rehabilitation	☐ HIV (AIDS)
	☐ Sexually Transmitted Diseases		☐ Genetics	☐ Psychotherapy Notes	
	☐ Other _____				

This authorization shall expire on: (Date or Event)	Signature of Individual or Personal Representative authorized by law:	Date:

IMPORTANT INFORMATION ABOUT AUTHORIZATION:

We may need your authorization to use, disclose or obtain your health information for some of our services. You do not have to sign this form. If my expiration date is not entered, the authorization will expire one (1) year from the date signed.

A separate signed authorization form is required for the use and disclosure of health information for:
☒ Psychotherapy notes ☒ Employment-related determinations by an employer ☒ Research purposes unrelated to your treatment

When required by law or policy, PHSC may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.
☒ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by l aw or policy, PHSC will use and disclose your health information as you have authorized on the signed authorization form.
☒ You may be required to sign an authorization before receiving research-related treatment.
☒ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. Example: In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by PHSC, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to PHSC.

☒ You may cancel an authorization in writing at any time. PHSC cannot take back any uses or disclosures already made before an authorization was cancelled.
☒ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by PHSC privacy policies.

Revised 2/6/2018