

## AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

(Please Complete All Highlighted Sections to Avoid Any Delays in Processing)

*Please Print*

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Patient #** \_\_\_\_\_  
Last First Middle (MM/DD/YYYY)

**Address:** \_\_\_\_\_  
Street City State Zip

**Phone Number:** \_\_\_\_\_ **E-Mail Address:** \_\_\_\_\_ **Date(s) of Service:** \_\_\_\_\_

**Purpose of Release:**

<input type="checkbox"/> Continuity of Care/ Treatment	<input type="checkbox"/> Leaving Practice/Change of Doctor (minimum document set)
<input type="checkbox"/> Self/Personal Reasons (minimum document set)	<input type="checkbox"/> Disability (minimum document set)
<input type="checkbox"/> Employment Related	<input type="checkbox"/> Research
<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> Insurance
	<input type="checkbox"/> Legal Reasons

I hereby authorize the release of my health information from the Practice/Organization named above to the Recipient named below.

Physician Practice/Organization Authorized to **Release** Information:

Person/Physician Practice/Organization Authorized to **Receive** Information:

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

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

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

**City, State & Zip:** \_\_\_\_\_

**City, State & Zip:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Information to be Released** – For the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all the documents listed.

<input type="checkbox"/> <b>Complete Record</b>	<input type="checkbox"/> <b>Minimum Documents</b> (the following will be sent) <ul style="list-style-type: none"> <li>Progress Notes – last 2 years</li> <li>Radiology (if applicable) – last 2 years</li> <li>Lab (if applicable) – last 2 years</li> <li>Other Diagnostic Tests (if applicable) – last 2 yrs</li> <li>Cardiovascular (if applicable) – last 2 years</li> <li>Consultations – last 2 years</li> <li>Hospital Records – last 2 years</li> </ul>	<input type="checkbox"/> <b>Additional Documents</b> (comprised of Minimum Documents plus the following selected items): <ul style="list-style-type: none"> <li><input type="checkbox"/> Physician Orders</li> <li><input type="checkbox"/> Nurses Notes</li> <li><input type="checkbox"/> Graphics</li> <li><input type="checkbox"/> Physical Therapy</li> <li><input type="checkbox"/> Medication Lists</li> <li><input type="checkbox"/> Other/Misc: _____</li> </ul>
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**Method of Release:**  
 Mail     Fax     Email     Other (please specify): \_\_\_\_\_

I authorize the release of records related to treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses.

**Expiration:** This authorization for release of protected health information for the date(s) of service indicated is effective until \_\_\_\_\_ or for a maximum of one year from the date signed below.

**Revocation:** I understand that I may revoke this authorization, in writing, at any time except to the extent that OneGI has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to the One GI Location that released the medical records

**Redisclosure:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Fees:** The fee will depend on the number of copies requested and the current rate allowed by state law.

OneGI does not condition treatment, payment enrollment or eligibility for benefits on the signing of this authorization.

Signature of Patient	Date	
Signature of Patient's Legal Representative	Relationship to Patient	Date

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).