# Authorization for Release of Protected Health Information (PHI) Form

Your health record is private and is known under the law as "Protected health Information (PHI). By completing and signing this from, you or your legal representative, agrees to allow your health plan to your PHI with people or companies listed below.

I authorize this practice to use or disclose my health information as described below:

**Patient Information:**

| First name: | Last name: | Middle initial: |
|---|---|---|
| Date of birth: | Phone number: | ID Number: |
| Street: | City, state, ZIP Code: | |

**PHI can be shared with the following people or companies:**

| Person or company name: | Phone number |
|---|---|
| Street | City, state, ZIP Code: |
| Person or company name: | Phone number |
| Street | City, state, ZIP Code: |

**By signing this form I authorize this Practice to disclose information below for the following purpose:**

Check one of the following options:

☐ At my request (no specific purpose) ☐ Specific purpose: _____

**This form will be valid for 1 YEAR unless a shorter time period is listed below:**

My authorization is valid

_____ _____

Date Date

**By signing below, I understand and agree:**

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed practice HIPAA Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that the practice will not condition the provision of treatment or payment on the provision of this authorization.

**Patient's signature or signature of the legal representative:**

| | |
|---|---|
| _____ | _____ |
| Patients Name | Name of Representative (if applicable) |
| _____ | _____ |
| Signature of Patient or Representative | Date |