AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name____

DOB ______________________________ Phone number ______________________________

1. **Entity who is authorized to release Patient's information: (*PHMG or other entity in ownership of records*)**

   Name ______________________________ Fax ____________________Phone ______________

2. **Entity(ies) to whom the Patient's information may be disclosed (Where the records will be going.)**

   Name ____

   Address____

   Phone ______________________________ Fax ______________________________

3. **The specific information that should be disclosed:**

   __________ LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS _________ LAST 12 MONTHS OFFICE NOTES/LABS/X-RAYS

   OTHER (BE SPECIFIC):

   ____

   Pick up______ Where?______________________________ Faxed______ Mailed______

4. **The purpose for the disclosure is:** ____

5. **This authorization will expire on the following date or event:** ______________________________

   If no expiration date or event is listed, the authorization will expire one year after the date of the authorization.

   WE PROVIDE THE PAST TWO YEARS OF RECORDS TO OTHER PROVIDERS (with a note to call if they need more) IF A PATIENT WANTS ARCHIVED RECORDS SENT TO THEMSELVES OR ANOTHER PROVIDER, THERE WILL BE COPYING FEES APPLIED AS FOLLOWS: (1-50 PAGES $15, 51-100 PAGES $25, OVER 100 PAGES $40) *All records given directly to patients will be copied to a disc*. Pre-payment is required.

   Signed:

   ____ Date____________________
   Patient

   ____ Authority______________________________
   Personal Representative (parent, guardian, etc.)

Updated 7/16