



**AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION**

Patient Name: _____

MRN: _____

for office use only

Address: _____

Date of Birth: _____

Telephone: _____

Information to be Released From:

Information to be Released To:

Doctor/Clinic Name: _____

Name: _____

Address: _____

Address: _____

Phone Number: _____

Phone Number: _____

Information to be released (MUST CHECK ALL THAT APPLY):

- | | | |
|---|--|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-Ray/Radiology Reports | <input type="checkbox"/> ECHO Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> EKG Reports | <input type="checkbox"/> Billing Information |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> EEG Reports | <input type="checkbox"/> Other _____ |

All records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: _____

Please indicate any restrictions. (Specify) _____

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purpose:

- Continued Care Insurance Legal Personal Use Other: _____

Information will be mailed unless otherwise stated here: _____

- I understand I may revoke this authorization by written request at any time to the address listed at the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____. The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand that once information is released pursuant to this authorization, UMPHysicians cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- A copy of this authorization is as valid as the original bearing my signature.
- Except for research-related treatment, UMPHysicians will not condition treatment on my signing this authorization.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

Signature of Patient/Legal Representative

Date

Time

Print Name of Legal Representative (if applicable)

Legal Representative's authority to sign
(parent, guardian, health care power of attorney, etc.)

REASON PATIENT IS UNABLE TO SIGN: MINOR DECEASED OTHER: _____