

MRN **Authorization for Release of Protected Health Information (PHI)**Patient Name _____ Date of Birth _____
Address _____ Telephone Number _____
I hereby authorize (name of facility/provider releasing information) **to disclose the above-named individuals health information:**

Name (facility releasing information) Address City State Zip

Telephone Number

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Radiology/Imaging reports |
| <input type="checkbox"/> Most recent history and physical | <input type="checkbox"/> Radiology films |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Two-way verbal exchange of communication |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Entire medical record |

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the information)

Name (facility receiving information) Address City State Zip

Telephone Number

Description of the purpose of the use and/or disclosure: (check one)

- | | | |
|--|---|--|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Emergency/acute care |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Insurance | <input type="checkbox"/> Social Security/Disability (provide copy of SSA Letter) |
| <input type="checkbox"/> Legal purposes | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other: Please describe: _____ |
- Marketing-If this request is for marketing purposes, ADC may receive remuneration from a properly authorized business associate as a result of using or disclosing the patient's protected health information (PHI).

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. The Austin Diagnostic Clinic may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I further understand that I may revoke this authorization at any time by notifying the Health Information Management Department at The Austin Diagnostic Clinic. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative_____
Date_____
Printed name of Patient or Patient's Representative_____
Relationship to Patient or_____
Legal Authority (attach supporting documentation)