Authorization to Disclose Protected Health Information

PATIENT INFORMATION

Name

Date of Birth (mm/dd/yyyy)

RECIPIENT INFORMATION

Name

Street Address **Apt. or Suite #** **City** **State** **Zip Code**

Phone Number

Email Address and/or Fax Number

PURPOSE(S)

☐ Patient/client's personal records ☐ To a Health Care provider for my treatment ☐ Other. Please describe:

RECORDS TO BE DISCLOSED (PLEASE CHECK ONE)

☐ My records for these dates:

☐ My records relating to:

☐ Other. Please specify:

RELEASE OF SENSITIVE INFORMATION

If your medical record contains the following types of records, they will be disclosed only if you initial next to each:

☐ Information relating to Acquired Immuno-deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken. **Initial**

☐ Genetic testing information including test results. **Initial**

☐ Information about sexually transmitted diseases **Initial**

DELIVERY OF RECORDS (PLEASE CHECK ONE)

☐ Physical copy to be delivered to Recipient by: ☐ Mail ☐ Fax ☐ Recipient will pick up

☐ Secure, encrypted email

☐ Regular (not encrypted) email. Note: We do not recommend regular email, as it will not be protected from interception during transmission.

Please sign here if you wish us to send the records in this non secure form.

☐ Other form. Please specify:

SIGNATURE

I understand that:

1. This Authorization is voluntary. I understand that my treatment by this health care provider does not depend upon my signing this Authorization. If I do not sign it, my records will not be released as directed in this Authorization.

2. This Authorization will expire on: _____ or 6 months after the date of my signature, whichever occurs first.
expiration date

3. After signing, I may revoke this Authorization at any time by providing a written notice of revocation to Danielsen Institute administrative staff; however any revocation will not affect disclosures made in reliance on this Authorization before receipt of my written revocation.

4. The information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

Signature of individual or Legally Authorized Representative **Date**

If Legally Authorized Representative, please specify relation to patient

FOR OFFICE USE

Date Authorization Received **Received by (name, title)** **Patient/Client Medical Record Number**

Please check all selections that apply:

☐ Patient or patient's friend/family member known to me picked up documents in person

☐ If records are picked up in person by someone other than patient, verify identity by picture ID:
☐ Driver's License ☐ State ID ☐ Passport ☐ Other ID:

☐ If mailing records, verify name and address of recipient

☐ If emailing, verify email address. Use encrypted email unless patient has authorized non-secure email in writing

☐ If signed by patient's Legally Authorized Representative, verify copy of court appointment or other documentation of representative's authority. Contact Office of the General Counsel or HIPAA Privacy Officer with questions.

Original Authorization:

☐ Keep in individual's record ☐ Copy to accompany release

Name of person fulfilling the request **Date completed**