AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize the use or disclosure of the protected health information ("PHI") as described below. By authorizing the use or disclosure of the PHI described below, I authorize the custodian of the PHI (1) to open the PHI for review or inspection by the person(s) identified below, and (2) to furnish the person(s) identified below with a copy of the PHI if he or she so requests.

Patient Name**:** ____ DOB**:** ___________ SS# ____________________

Description of PHI requested (provide a specific and meaningful description of the information sought, including dates of service where applicable):

I authorize ____

to release and/or disclose the PHI described above to: ____

The purpose of this request to release and/or disclose the PHI described above is:

☐ Pending personal injury litigation ☐ Potential medical malpractice litigation ☐ Other pending litigation

☐ Other (describe) ____

I ☐ do ☐ do not authorize the recipient to redisclose the PHI described above.

I understand that I have the right to revoke this Authorization, in writing, at any time by so notifying the requesting person. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation.

I understand that my health care provider cannot condition medical treatment on whether I sign this Authorization.

This Authorization will expire ____________________________.

____ ____________________________
Signature of patient or patient's authorized representative Date

If signed by patient's authorized representative, describe the representative's authority:

☐ Patient is a minor; I am the patient's parent and natural guardian.

☐ Patient is a minor; I am the patient's guardian, appointed by the ______________________ County Juvenile Court.

☐ Patient is a ward; I am the patient's guardian, appointed by the ______________________ County Probate Court.

☐ The patient is deceased. I am the patient's surviving spouse or I am the executor or administrator of the patient's estate, appointed by the ______________________ County Probate Court.

☐ I am the patient's agent, as designated in the patient's Durable Power of Attorney for Health Care.

☐ I am the patient's agent, empowered to make the foregoing request, as designated in the patient's general durable power of attorney.

☐ Other (describe) ____

This Authorization to Release Protected Health Information is designed to meet the requirements of a valid authorization, as specified by the Standards for Privacy of Individually Identifiable Health Information (the HIPAA Privacy Rule*), 45 CFR., Parts 160 and 164. The prescribed content of a valid authorization is found at 45 CFR 164.508.*