

AUTHORIZATION FOR DISCLOSURE OF Protected Health Information

PATIENT NAME			
ADDRESS			
PHONE NUMBER	SOCI	AL SECURITY NUMBER	
DATE OF BIRTH	MAIC	DEN NAME	
I HEREBY AUTHORIZE:			
NAME, TITLE			
ORGANIZATIONS/DEPARTMENT, ADI	DRESS, PHONE NUMBER		
To release information fro	m my health record t	o:	
NAME, TITLE			
ORGANIZATIONS/DEPARTMENT, ADI	DRESS, PHONE NUMBER		
This authorization covers the follow	wing records:		
☐ All records			
☐ My record for treatment of		(please specify	diagnosis or symptom.)
		period (please give dates	
•		·	
I authorize release of information f	or the following reason:		
	=		
☐ Transfer/continuation for medic	•		
☐ Other (please specify)			
	-1 611		
Sensitive Information		f information will NOT be released from you	
Sensitive information		To authorize release, <u>sign your complete na</u>	<u>ime</u> next to the categories
	of information you want re	leased.	
Abortion	Date of TX	Mental Health	Date of TX
Substance Abuse (alcohol/drugs) _	Date of TX	Sexually Transmitted Diseases	Date of TX
Infertility Studies	Date of TX		
HIV test results or information ide	ntifying me as having taken	an HIV test	Date of TX
This authorization is valid for this requ	est only and will not be honore	d for any subsequent requests.	
This authorization for disclosure (unless	ss expressly revoked earlier) exp	oires after ninety days.	
I understand that I may revoke this aut	horization at any time by makir	ng a request in writing to the Privacy Officer of Fe	nway Health.
		lart 2 and may not be disclosed without my specif ords from re-disclosure by any third party.	fic authorization.
•	•	lly understand the above statements as they appl	y to me, and do voluntarily
Patient's signature or if authorized age	nt signature, please specify rela	tionship to patient. Date	
Witnesses signature		Date	