Cincinnati GI

Medical Record Release

Authorization for Use Disclosure of Protected Health Information (PHI)

This Authorization is according to Federal Privacy Laws.

Patient Information

Last Name _____ First_____ Middle_____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____/_____/_____ Phone # (_____)_____

I, the above identified person, do hereby authorize the release of my PHI as indicated

--must identify individual/group/entity and list addresses.

From: _____ To: _____

_____ _____

_____ _____

_____ _____

I understand that this authorization is voluntary and that it may include information relating to *AIDS, HIV infection, behavioral health services/psychiatric care, and/or treatment for alcohol and/or drug abuse.* I understand that if the person/entity that receives my Protected Health Information is not covered by Federal Privacy regulations, the PHI described below may be re-disclosed by such person or entity. I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party such as when requested by my employer.

Patient's Signature _____

This authorization covers the following periods of healthcare: (please check one)

_____All periods of healthcare

_____From ____/____/____ to ____/____/____