These instructions were designed to help answer any questions that may arise when completing the *Authorization Form for the Release of Protected Health Information*.

**Section A**-

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| **Patient’s Name** | The name of the person who received the medical service(s). |
| **Birth Date** | The patient’s date of birth. |
| **Patient’s Address** | Address for the patient |
| **Patient’s Phone** | A phone number where the patient may be reached. |
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**Section B**

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| **Description of Information to be Used or Disclosed** | ***Description***- Mark the box that best describes the type of health information requested for use or disclosure.  ***Date of Service***- Provide the date of service related to when the medical treatment was rendered. If the requested information being requested pertains to an inpatient hospital stay, provide the discharge date.  ***Consent to Release***- Initial this box if you acknowledge and consent to the release of protected health information that may contain alcohol/drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. Check box to the right if not applicable. |
| **Purpose of Disclosure** | Explain why the requested protected health information is being requested. |
| **Psychotherapy Notes** | Mark the “Yes” box if the information being requested is Psychotherapy-related. Mark the “No” box if the information is not related to Psychotherapy. |

**Section C**

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| **Provider’s Name** | Name of the facility or hospital where the patient service was performed. |
| **Provider’s Address** | Complete Mailing Address of the facility or hospital. **- *This field is optional.*** |
| **Recipient’s Name** | Name of the person being authorized by the patient to receive the requested protected health information. |
| **Recipient’s Phone** | A phone number where the recipient of the medical information can be reached. |
| **Recipient’s Address** | Complete mailing address for the designated “Recipient.” Please be sure to include your zip code. |
| **Email** | Complete only if eDelivery is requested. |
| **Request Delivery** | Specify how the recipient is to receive the requested information. |
| **Expiration Date or Event** | Authorization will expire in 1 year unless otherwise noted on this form. |

**Section D-**

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| **Signature of Patient/Guardian or Personal Representative** | The patient’s signature is always required, unless the patient is a minor or a legal representative has been appointed. |
| **Date Signed** | Provide the date that this authorization form was signed. |
| **Printed Name of Patient/Guardian of Personal Representative** | Print the name of the individual who signed this authorization form. |
| **Relationship of Personal Representative to Patient** | If someone other than the patient signs the authorization form, a description of the representative’s authority to act on behalf of the patient must be provided (i.e. Medical Power of Attorney, Executor of Estate, or Legal Guardian). Also, please include a copy of all supporting documentation (i.e. a copy of the medical power of attorney, court order for Executor of Estate, or court order for guardianship. |