Center for Adult and Pediatric Wellness
Yazen Joudeh, MD
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth: _____

Social Security #: _____

Information to Be Released – Covering the Periods of Health Care

From (date) _____to (date) _____

Please check type of information to be released:

_____Complete health record
_____Complete billing record
_____Consultation reports
_____Discharge summary
_____Other (please specify)

_____History and physical examination
_____Laboratory results
_____ X-ray reports
_____Pathology reports

Purpose of Request

_____ Treatment or Consultation
_____ At the request of the patient
_____ Billing or claims payment
_____ Other (specify) _____

Request Copies of My Records From:

Name: _____
Address: _____
_____

Send Copies of My Records To:

Name: _____
Address: _____
_____

Drug, Alcohol Abuse, Psychiatric, and/or HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. **(Circle One)**

Drug/Alcohol Abuse Yes or No **Psychiatric** Yes or No **HIV/AIDS** Yes or No

I understand that: I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management (Medical Records) Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire on _____. If no date is specified, this authorization will expire six months after the date it is signed by the Patient or the Patient's Legal Representative.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may or may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.

I have the right to receive a copy of this authorization. I have fully read and understand the nature of this Authorization and accept its terms. I authorize the Center for Adult and Pediatric Wellness to disclose and release the specific PHI, as indicated, for the specific use(s) and purpose(s) listed.

_____ _____
Signature of Patient or Legal Representative* Date

*State relationship to patient and attach applicable documents for guardianship and/or Power of Attorney.

_____

Witness Date _____