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Instructions for Completing the AUTHORIZATION FORM

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

Patient's Name: The name of the person who received the medical service(s).

Birth Date: The patient's date of birth.

Patient's Phone: The patient's phone number

Last 4 digits of Social Security Number: The last 4 digits of the patient's SSN (optional)

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 Address: Complete Mailing Address for the designated "Recipient".

Request Delivery Method: Records may be sent as a paper copy or through electronic media (if available), encrypted email or unencrypted email (sending through unencrypted email carries a risk that a third party may be able to see your information)

Email Address: Recipient's email address if requesting to receive via email

Expiration Date or Event: Provide the expiration date (or) an expiration event when this authorization will terminate. Provide one or the other.

Purpose of Disclosure: Explain why the requested protected health information is being used or disclosed (Personal, Continuity of Care- recipient is another healthcare provider)

Description of Information to be Used or Disclosed:

***Psychotherapy Notes*:** Mark the "Yes" box if the information being requested is Psychotherapy related. Mark the "No" box if the information does not relate to Psychotherapy.

Description: Mark the box that best describes the type of health information being requested for use or disclosure. Most of these items relate to specific medical provider records. *There is a fee ($0.25 per page) so please only request the documents that are necessary to avoid additional charges.

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Date of Service:	Provide the date of service when the medical treatment was rendered. If the information being requested pertains to an inpatient hospital stay, provide the discharge date. If a copy of a billing statement is being requested, you can specify the statement date.
Consent to Release:	Initial this box if you acknowledge and consent to the release of information that may contain alcohol/drug abuse, psychartriac, HIV testing, HIV results or AIDS information. Check box to right if not applicable.

Section B

This section needs to be completed only if the request is for marketing purposes (and) the patient received compensation in exchange for using or disclosing this information. Select Yes (or) No. If yes, provide a brief explanation.

Section C – Required Signatures

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 the authorization form was signed.
Printed Name of Patient/Guardian (or) Personal Representative:	Print the name of the individual who signed the 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. (e.g. Power of Attorney, Trustee, Conservator, Executor of Estate, or Legal Guardian)