CRH PHYSICIAN PRACTICE, LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____

to disclose the following information from the health records of the individual whose name is specified below:

Patient Name _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone Number _____ **Social Security Number** _____

I authorize the above named facility to release medical, mental, alcohol and / or drug abuse, HIV testing, AIDS, eating disorders or anything other medical information of a sensitive nature to provider(s) listed below.

Provider: _____ **Fax number:** _____

Provider: _____ **Fax number:** _____

Provider: _____ **Fax number:** _____

The purpose of this request of PHI Disclosure is for: ☐ **Continuation of Medical Care** ☐ **Transfer of Care**

Specific date(s) of service to be released: _____

The type of information to be disclosed is as follows:

☐ Entire Record
☐ X-Rays/Imaging
☐ Discharge Summary
☐ Emergency Room Report
☐ Progress Notes/Office Notes
☐ History & Physical Reports
☐ Consultation Reports
☐ Lab Results
☐ Abstract
☐ Operative Reports
☐ Other _____

I understand that this authorization shall remain valid for one year from the date signed below. I understand that I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to the department of the facility listed on this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____

Signature **Date**

Signed by: ☐ Patient or Authorized Person ☐ Parent ☐ Legal Guardian ☐ Executor/Power of Attorney

_____

Witness Signature **Date**