



# Children's International<sup>®</sup>

## MEDICAL GROUP

### AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST, MIDDLE)		DOB
ADDRESS		SSN
CITY	STATE	ZIP CODE

<b>PROVIDER AUTHORIZED TO RELEASE PHI</b>	<b>ENTITY RECEIVING PHI</b>

This authorization will expire on the following date or event. If the date or event is not indicated, authorization will expire 12 months from the date signed.

**Date:** \_\_\_\_\_ **Event:** \_\_\_\_\_

#### PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

	START DATE	END DATE
<input type="checkbox"/> ALL PHI IN THE RECORD		
<input type="checkbox"/> PROGRESS NOTES		
<input type="checkbox"/> LABORATORY RECORDS		
<input type="checkbox"/> X-RAY TEST & REPORTS		
<input type="checkbox"/> HISTORY AND PHYSICAL EXAMINATIONS		
<input type="checkbox"/> DISCHARGE SUMMARYS		
<input type="checkbox"/> CONSULTATION REPORTS		
<input type="checkbox"/> ITEMIZED BILLING STATEMENTS		
<input type="checkbox"/> OTHER		

The following information will be released when included in the above information unless you indicate otherwise:

- AIDS OR HIV test results                       psychiatric or mental care/treatment  
 Alcohol, drug, or substance abuse treatment                       other (specify):

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have a right to receive a copy of this form after I sign it.

SIGNATURE OF PATIENT:	DATE:
SIGNATURE OF PATIENTS REPRESENTATIVE (IF NECESSARY):	DATE:

PERSONAL REPRESENTATIVE'S RELATIONSHIP TO THE PATIENT: