



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

Medical Record #	Account #
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Section A: (All Sections must be complete to be valid)

Patient Name:	Date of Birth: / /	Social Security #:
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I hereby authorize Brooks Health System to Release/Receive my Confidential Health Information To/From:

Name/Facility:	Phone Number:
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Address:	City:	State:	Zip:
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Purpose of disclosure: <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal Use	<input type="checkbox"/> Insurance Purposes <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Legal reasons	Type of Access: <input type="checkbox"/> Copies of Record <input type="checkbox"/> Review of Record
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Section B: Description of information to be used or disclosed

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> Admission Documentation <input type="checkbox"/> History & Physical <input type="checkbox"/> Physician orders <input type="checkbox"/> Progress Notes <input type="checkbox"/> Discharge Summary		<input type="checkbox"/> Consultation Reports <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Clinical Tests <input type="checkbox"/> Evaluations/Assessments		<input type="checkbox"/> Medication Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> Diagnosis <input type="checkbox"/> Other: _____	

I acknowledge, and hereby consent to such, that the released information may contain HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions.
(Initial here)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the No notice of Privacy Practices.
4. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations.
5. I understand that if I ask, I may see and obtain a copy of the information to be used or disclosed pursuant to this authorization.
6. I get a copy of this form after I sign it, if requested.
7. If I fail to specify an expiration date or condition as set forth below, this authorization is valid for six months from the signature date.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:	Signature of Witness:
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Medical Record #

Account #

Name of Patient/Guardian/Patient Representative:

Relationship to Patient:

authorization will expire six months from the date signed unless otherwise specified below:
Expiration Date/Event:

