Children's International®
MEDICAL GROUP

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

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

| PROVIDER AUTHORIZED TO RELEASE PHI | ENTITY RECEIVING PHI |
|---|---|
| | |

**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 |
|---|---|---|
| ( ) ALL PHI IN THE RECORD | | |
| ( ) PROGRESS NOTES | | |
| ( ) LABORTORY RECORDS | | |
| ( ) X-RAY TEST & REPORTS | | |
| ( ) HISTORY AND PHYSICAL EXAMINATIONS | | |
| ( ) DISCHARGE SUMMARYS | | |
| ( ) CONSULTATION REPORTS | | |
| ( ) ITEMIZED BILLING STATEMENTS | | |
| ( ) 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: | |