Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Last four digits of SSN: *(optional)*:**
Provider's Name:	**Recipient's Name:**	
Provider's Address:	**Address 1:**	
	Address 2:	
	City:	**State:** **Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD, email) NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy)**

Email Address (If email checked above. Please print legibly):

This authorization will expire twelve months after the date of the patient or patient's representative signature date below in Section C.
If patient or patient's representative wishes to have authorization expire sooner, fill in the requested date of expiration below:
Date authorization to expire:

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record (not including photos) ☐ Physics & Dosimetry Notes ☐ Consults ☐ History and Physical ☐ Physician Follow Up Notes ☐ Physician Correspondence ☐ Medication Sheets		☐ Lab and Pathology Reports ☐ Port Films ☐ Nursing Notes ☐ Diagnostic Images ☐ Diagnostic Reports ☐ Treatment Notes ☐ Itemized Bill(s)		☐ Operative Reports ☐ Billing Information ☐ Other: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

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 may 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 Notice of Privacy Practices.
4. If the requester 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 redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and /or does it involve the sale of PHI?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for further remuneration? ☐ Yes ☐ No

Section C: Signatures

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

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**