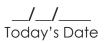
## Authorization for Release of Protected Health Information





ent Name Date of Birth			
otected Health Information (PHI) to b	e released from:		
Entity Name			
Address	City	State	ZIP
Phone #	Fax #		
Email Address			
out the above patient to the followin	is authorized to release protec	ted health inform	ation (PH
of the above patient to the following	ig party below.		
Entity Name			
Address	City	State	ZIP
Phone #	Fax #		
Email Address			
the medical data or information the	at is to be used or disclosed:		
Entire Medical Records			
Progress Notes			
Lab and Test Results			
Other:			
Physician Notes			
I understand that if my records contain documes information will be released as a part of my record	ntation of alcohol abuse, psychiatric condition, di	rug abuse, or communical	ole diseases,
	his information is not covered by federal privacy r	egulations, this information	on will no lor
I understand that I may revoke this authorizatio Revocation must be in writing and should be sent	n at any time, but revocation will not apply to ir to the address noted at the top of this form.	nformation that has alread	y been releas
I understand that I may refuse to sign this authori	ization and that my refusal to sign will not affect m	y ability to obtain treatme	nt.
I understand that there may be charge for obtain entity at the top of this form.	ing the requested information. Information on the	charge can be obtained b	y contacting
I understand that this authorization will expire or	ne (1) year after signed unless an earlier date, cond	ition, or event is specified.	
ient/Guardian Sianature		Do	110