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

SECTION A: ***Will the protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the authorized for Research Form. If no, proceed to section B.***

WESTSIDE PRIMARY CARE

SECTION B***: Required if all Authorizations for Release of PHI or Right to Access***

| **Patient Name** | **Date of Birth** | **Soc. Security #** *(optional* |
|---|---|---|
| **Patient Address** | **Requestors Name & Phone #** *(if patient is not the requestor)* | |

| **PHI Recipient Name:** | **Address/City/State/Zip** | **Phone#**<br>**Fax#** |
|---|---|---|
| **PHI Sender Name:** | **Address/City/State/Zip** | **Phone#**<br>**Fax#** |

**This authorization will expire on the following: (Fill in the Date or Event, but not both.)**

**Date:** **Event**

**Purpose of Disclosure:**

**Is this request for psychotherapy notes?**

- ❑ **Yes, then this is the only item you may request on this authorization.**
- ❑ **No, then you may check as many items below as you need.**

| **Description:** | **Date(s)** | **Description:** | **Date(s)** | **Description:** | **Date(s)** |
|---|---|---|---|---|---|
| ❑ **All PHI in record**<br>❑ **History & Physical**<br>❑ **Consult Report**<br>❑ **Operative Report**<br>❑ **Progress Notes** | | ❑ **Physician Orders**<br>❑ **Laboratory**<br>❑ **Imaging/Radiology**<br>❑ **Nursing Notes**<br>❑ **Medication Records** | | ❑ **Demographics**<br>❑ **Rehabilitation Services**<br>❑ **Special Test Therapy**<br>❑ **Itemized Bill Claims**<br>❑ **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). If not applicable, check here: ❑

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).

2. 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.

3. If the requestor or the 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 re-disclosed.

4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

5. I will receive a copy of this form after I sign it.

## SECTION C: SIGNATURES

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

| Signature of Patient/Guardian/Patient Representative: | Date: |
|---|---|
| Print Name of PatientÕs Representative: | Relationship to Patient: |