

**Patient Authorization of Disclosure**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_

In general, HIPPA Privacy Rules gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The Individual is also provided the right to request confidential communications of PHI made by alternative means, such as sending correspondence to the individual’s office instead of the individuals home. The patient may revoke or change this authorization at any time with a written request.

**Prime MD, May contact you by:**

 ❒ Home, Cell, Work Phone

 ❒ E-mail

 ❒ Patient Portal

**If we are unable to reach you:**

 ❒ You may leave a detailed message

 ❒ Please leave a message asking me to return your call/email.

 ❒ Do not leave a message

**I authorize the release of information including diagnosis, records, examinations rendered to me and claims information.**

 ❒ This information may be released to:

1) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

   Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

    Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

    Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ❒Information is not to be released to anyone.

**Patient Name/Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**