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Care, P.A.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ Date of Birth _____

INFORMATION REQUESTED FROM:	INFORMATION REQUESTED FROM:
NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____
TELEPHONE: _____	TELEPHONE: _____
FAX NO# _____	FAX NO# _____

INFORMATION TO BE DISCLOSED (PLEASE SPECIFY)

Description	Date(s)	Description	Dates(s)	Description	Date(s)
Admission Form		Invasive Procedure Doc		<i>Confidential Information</i>	
Physician Dictated Reports		Documentation		HIV Testing	
Physician Orders		Medical Sheets		HIV & AIDS	
Physician Progress Notes		X-Ray Films		documentation	
ER Documentation		Pathology Slides		Psychiatric	
X-ray Reports		Other _____		documentation	
Laboratory Reports		Other _____		Alcohol & Drug	
EKG(s)		Other _____		Abuse documentation	
Operative Documentation		Entire Medical Record			

PURPOSE OF DISCLOSURE

Continuing care with another physician or hospital Personal Copy Other (specify) _____

AUTHORIZATION

I understand that:

This authorization will remain in effect for 30 days.

1. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
2. I may refuse to sign this authorization and that it is strictly voluntary.
3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing authorization.
4. If the requestors or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulation and may be disclosed.
5. 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.
6. I will receive a copy of this form.

I acknowledge, and hereby consent to such, that the protected health information released may contain alcohol, drug, abuse, psychiatric, HIV testing, HIV results or AIDS information. I also acknowledge I have read the above and authorize the disclosure of the protected health information stated.

PARENT/GUARDINAN
 SIGNATURE _____

DATE _____

PARENT/GUARDINAN
 PRINTED NAME _____

DATE _____

WITNESS SIGNATURE _____

DATE _____