Patient Authorization for PHI Disclosure

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____ / _____ / _____

Recipient Information:

- **Name/Organization:** _____
- **Relationship to Patient:** _____
- **Phone Number:** _____

Information to be Disclosed:

- Full Medical Record
- Lab Results
- Medication History
- Visit Summaries
- Other (specify): _____

Purposes of this Disclosure:

- Continued Care

- Personal Use
- Insurance
- Other (specify): _____

Authorization Expiration:

This authorization expires on: _____ / _____ / _____

(If left blank, it expires 5 years from the date signed.)

Patient Rights:

- I may revoke this authorization at any time by notifying the clinic in writing.
- Information disclosed per this authorization may no longer be protected by privacy laws once released.

Signature:

- **Patient or Legal Representative:** _____
- **Date:** _____ / _____ / _____

Clinic Use Only:

Received by: _____ *Date:* _____ / _____ / _____