DISCLOSURE AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

DATE: _____

PATIENT NAME: _____ **PATIENT #:** _____

ADDRESS: _____

_____

COMMUNICATION OF HEALTH INFORMATION

I give permission to Comprehensive Hand & PT **to disclose and discuss any information related to my medical condition(s) with the following individuals:**

_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**
_____	_____
Name	**Relationship**

METHOD OF CONTACT

I wish to be contacted in the following manner(s):

_____ **Home Telephone**

[ ] OK to leave a message with detailed information

[ ] Leave message with call-back number only

[ ] OK to leave message with family members or other persons living in the same household

_____ **Work Telephone**

[ ] OK to leave a message with detailed information

[ ] Leave message with call-back number only

[ ] OK to leave message with secretary, assistant or other individual who regularly answers phone

_____ **Cell Phone**

[ ] OK to leave a message with detailed information

[ ] Leave message with call-back number only

RELEASE OF INFORMATION

RELEASE INFORMATION TO: _____

I hereby authorize Comprehensive Hand & PT **to release to the above referenced individual(s) or entity(ies), copies of the following medical records, including mental health information and such reports and/or records pertaining to a serious or communicable disease or infection pertaining to myself:**

- ☐ **Evaluation**
- ☐ **Daily Notes**
- ☐ **Discharge Summary**
- ☐ **Testing**
- ☐ **Progress Notes**
- ☐ **All Records**
- ☐ **Other (describe)** _____

Dates of Service Requested _____

- ☐ **I would like photocopies mailed to me.**
- ☐ **I would like to arrange to pick records up in the clinic.**

The above identified information is released solely for the following purpose and that purpose only:

_____

_____

_____

This authorization will expire one hundred and eighty (180) days from the date of signature, or sooner if specifically revoked below (except to the extent that action has been taken in reliance on it).

_____ _____

Signature of Patient or Authorized Legal Representative (Describe basis of authority) **Date**

_____ _____

Witness Signature **Date**

_____

Printed Witness Name and Relationship to Patient

Authorization Revoked:

_____ _____

Patient Signature **Date**

Revised 06.02.2010kb