Authorization for Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____
Address: _____
Phone: _____

Proliance may disclose health information from:
☐ A specific location: _____
☐ All of Proliance

Proliance may disclose the following health information:
☐ Current medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc within the last 12 months)
☐ All medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc)
☐ Health care information in my medical record related to the following treatment/condition: _____
☐ Health care information in my medical record for the date(s): _____
☐ X-ray images
☐ MRI images
☐ Billing information

Proliance may disclose health care information regarding testing, diagnosis, and treatment for the following:
☐ HIV (AIDs virus)
☐ Sexually transmitted disease
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

Proliance may disclosure this health care information to:
Name (or title) and organization: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____ Email: _____

Preferred method of delivery: ☐ Print ☐ Fax ☐ Secure Email ☐Electronic Media (CD/Flash Drive)

Reasons for this authorization:
☐ At my request
☐ Other: _____

This authorization expires: (This authorization will expire in ninety (90) days after date signed unless the below is specified)
☐ On date: _____
☐ When the following event occurs: _____

My Rights – I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider. If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of patient Relationship (parent, personal representative, etc)