

HIMROI001 - (9/2017)

Patient Label

Physician Practices Authorization to Disclose Protected Health Information



| Address: | Phone#: | Fax#: |
|--|--|--|
| To release the information from the record of: | | |
| Patient Name: | SSN/Medical Rec | cord Number: |
| Date of Birth: | Daytime Phone N | Number: |
| Address: | | |
| Documentation can be released electron Please check with your facility to determ | • | |
| The following information will be released with | | |
| ☐ Physician/provider visit documentation | ☐ Medication list | For the Purpose of: |
| (from date to date | ☐ Immunization record☐ Billing | (Choose only one option below) |
| / □ Laboratory results | Other: | Verbal Communication |
| from date to date | | |
|) | | Copies of Medical Records |
| □ X-ray reports | | |
| (from date to date | | Continuity of Care |
|) | | |
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| acquired immunodeficiency syndrome (AIDS), or behavior or mental health services, genetic testin unless otherwise indicated: | human immunodeficiency virus | s (HIV). It may also include information about |
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