# HCA PHYSICIAN SERVICES

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

**Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient?** If yes, complete the Authorization for Research Form. If no, proceed to Section B.

**Section B: Required for all Authorizations for Release of PHI or Right to Access**

| Patient Name: | Birth Date: | Social Security No. *(optional)*: |
|---|---|---|
| Patient's Address: | Requestor's Name/Phone Number (if patient is not the requestor): | |

| PHI Recipient Name: | Address/City/State/Zip | Phone Number: (__) _____<br>Fax Number: (__) _____ |
|---|---|---|
| PHI Sender Name: | Address/City/State/Zip | Phone Number: (__) _____<br>Fax Number: (__) _____ |

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

| Description: | Date(s) | Description: | Date(s) | Description: | Date(s) |
|---|---|---|---|---|---|
| ☐ All PHI in record<br>☐ History and Physical<br>☐ Consult Report<br>☐ Operative Report<br>☐ Progress Notes | | ☐ Physician Orders<br>☐ Laboratory<br>☐ Imaging/Radiology<br>☐ Nursing Notes<br>☐ Medication Record | | ☐ Demographics<br>☐ Rehabilitation Services<br>☐ Special Test/Therapy<br>☐ Itemized Bill/Claims<br>☐ Other: | |

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

**Section C: Signatures**

**I have read the above and authorize the disclosure of the protected health information as stated.**

| Signature of Patient/Guardian/Patient Representative: | Date: |
|---|---|
| Print Name of Patient's Representative: | Relationship to Patient: |

Original – Practice
Copy – Patient
Copy – Recipient

HIM.PRI.001, PS 70-190 Authorizations



**Revision Date:** April 15, 2005