ASPIRUS™
Passion for excellence.
Compassion for people.

Authorization for Disclosure of Protected Health Information

Patient Name _____ Previous last name(s) _____

Address _____ Date of Birth _____

City, State, Zip Code _____ Telephone _____

I authorize the use and/or disclosure of my protected health information:
I understand that my protected health information that I am authorizing to be disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), infection with the Human Immunodeficiency Virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. **If I do not intend for this information to be disclosed, I understand that I will need to cross out the statement above and initial here.** _____

FROM:	**TO:**
Organization/Provider _____	Organization/Individual _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
_____	Phone Number _____ Fax _____

Information to be disclosed includes:

Hospital Record:
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Lab/Pathology Reports
- ☐ Operative/Procedure Report
- ☐ Radiology/X-Ray Reports
- ☐ Emergency Report
- ☐ Consultations
- ☐ EKG Reports
- ☐ Other _____

Clinic Record:
- ☐ Office Visit Notes
- ☐ Radiology/X-Ray Reports
- ☐ Lab/Pathology Reports
- ☐ EKG Reports
- ☐ Other _____

Delivery Method:
- ☐ Pick-Up
- ☐ Mail
- ☐ Other _____

Dates of Service: _____

Purpose for disclosure (Optional):
- ☐ Medical Care
- ☐ Insurance
- ☐ Legal
- ☐ Personal
- ☐ Disability Determination
- ☐ Worker's Compensation
- ☐ Law Enforcement
- ☐ Social Services
- ☐ Other (specify): _____

Fees: I understand that fees may apply to process my medical record request.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event (Specify):

_____

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Parent/Legal Representative Relationship Date