

Authorization to Disclose Protected Health Information

Patient Information (Please Print)

First Name:		Middle Initial:		Last Name:	
Date of Birth:		Phone:		E-mail (optional):	
Address:		City:		State:	Zip:

Please process this authorization now. Please keep this authorization on file for possible disclosure later.

I authorize: Madisonhealth Other: _____

To disclose to: Self

and/or Third-Party _____ Address _____ Phone _____ Fax _____ Email _____	Third-Party _____ Address _____ Phone _____ Fax _____ Email _____
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The following type(s) of information per this authorization:

- Any information concerning the patient's health, health care, or payment during the relevant time period.
- Only the following health records from the relevant time period:
 - Consultation Report Emergency Room Record Last PO Intake Operative Report Physician's Progress Notes ALL
 - Discharge Summary History & Physical Nurses Notes Pathology Report Radiology Images
 - EKG Lab Reports Office Notes Physician's Orders Radiology Reports
- Billing and payment records for care rendered during the relevant time period.
- Other: _____

Records or Information relating to the following time period:

- The patient's health care at anytime.
- The patient's health care between (date) _____ and (date) _____.

Purpose for use or disclosure:

- Personal Legal/Attorney/Subpoena Disability Request
- Insurance Treatment/Continuing Medical Care Other: _____

Delivery: Paper: In-person Pickup Mail or

Electronic: Secure email Unsecure email CD
I consent and accept risk of transmitting PHI via unsecure email. () initials

Rights & Limits: I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date this authorization is dated.** I need not sign this form in order to assure treatment. I understand that once protected health information is disclosed to others, the protected health information may be disclosed to individuals or organizations not subject to the Health Insurance Portability and Accountability Act and may no longer be protected by HIPAA.

Signature of Patient or Legal Representative:	Date:
Printed name of Legal Representative:	

Legal Representative's Authority:
<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Healthcare Power of Attorney
<input type="checkbox"/> Other, explain: _____

OFFICE USE ONLY: Authorizer's ID Verified | ID of 3rd Party Receiving Records Verified | Completed by: _____

Patient Telephone Request (verified): SSN or DL# DOB Presenting illness Address (3 of 4 required)

Date released: ____ / ____ / ____ Info already released Needs to be released Copy of ROI to Patient