# Limited Patient Authorization for Disclosure of Protected Health Information

**Please Print or Type All Information.**

Patient Name: ______________________________

SSN (last four digits):______________________________

Date of Birth: ______________________________

**Entity Requested to Release Information**

Individual/Entity Name: ______________________________

Address: ______________________________

Phone:______________________________

**Purpose of Request** (who will be authorized to receive information)
I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

**Who Will be Authorized to Receive Information** (list the individual/entity who is to receive your PHI)

Individual/Entity Name: ______________________________

Address: ______________________________

Phone:______________________________

**Description of Information to be Disclosed**
I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

❑ Entire patient record: or, check only those items of the record to be disclosed:

- ❑ Office notes
- ❑ Lab results, pathology reports
- ❑ X-rays
- ❑ Nursing home, home health, hospice, and other physician records
- ❑ Record of HIV and communicable disease testing
- ❑ Record of mental health or substance abuse treatment
- ❑ Financial history report (previous 3 years only)
- ❑ Only send the following:

**Purpose of Disclosure** (please record the purpose of the disclosure or check patient request):

❑ Patient Request ❑ Other (please specify):______________________________

** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.*

**You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager.*

**This authorization will expire at the end of the calendar year from the date on this form.*

**The practice places no condition to sign this authorization on the delivery of healthcare or treatment.*

Patient or representative signature ______________________________ Date ______________

*You have the right to receive a copy of signed authorizations upon request.*