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HIPPA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____
FIRST NAME M I LAST NAME SS # DATE OF BIRTH

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP CODE

HOME #: _____ WORK #: _____ CELL #: _____

I authorize the release of my Protected Health Information voluntarily to:

Doctor's Name_____

Phone Number: _____ Fax Number: _____

Address/City/State/Zip: _____

PHI requested from:

Doctor's Name_____

Phone Number: _____ Fax Number: _____

Address/City/State/Zip: _____

Receipt of Records: Please check one: Pick up ☐ Mail ☐ Fax ☐

PURPOSE FOR RELEASING PROTECTED HEALTH INFORMATION

☐ Transferring Physician ☐ Referral for continued Medical Care ☐ Legal Action

☐ Insurance Requirements ☐ Moving (provide date of move)

☐ Other (please specify) _____

Signature of Authorizing Party: _____ Date: _____

Print Signature: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

Completed by: _____ Date: _____

ATTENTION:
This fax may contain confidential medical information. Should you receive this fax in error, you are required to contact us immediately at (229) 333-0616.