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Authorization for Release of PHI

Today's Date:______________________
Patient's Name:______________________________ Date of Birth:____________
Address:____
City/State/Zip Code:____
Patient's Phone #: (   )_________________

Select the following types of Authorization that apply. Psychiatric and alcohol/drug treatment records are not included in this authorization unless you complete the following section giving specific permission to do so.

__Medical/Surgical Information   __ Psychiatric Information   __Alcohol/Drug Abuse Information

Please check all information that applies:

__All Information   __Progress Notes   __Hospital Information   __Treatment Plans   __ H & P
__Lab Results   __Radiology Reports   __Psychiatric Information   __Immunizations
__Other (please specify):____

__ I authorize Westside Pediatric Group to **RELEASE** my protected health information **TO**:
Name:_______________________________ City:_______________ State_______
Address:____ Zip:______
Phone #:_____________________________ Fax#:_____________________________

__I authorize Westside Pediatric Group to **OBTAIN** my protected health information **FROM:**
Name:_______________________________ City:_______________ State_______
Address:____ Zip:______
Phone #:_____________________________ Fax#:_____________________________

PURPOSE FOR THIS REQUEST: (Circle one)
2nd Opinion   Personal   Insurance   Transfer   Other ______________________
Please specify

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance from my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by the privacy regulations the information stated above could be re-disclosed. (If you are not the intended recipient, or the agent responsible to deliver to the intended recipient, you are hereby notified that nay disclosure, copying or distribution of this information is **strictly prohibited**.)
- There may be a charge for the requested records.

Signature of Patient or legal representative: __________________________________ Date______________

Relationship to Patient: ____________________________________
(if requestor is not the patient)

5/2015