Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for this clinician and its affiliates to communicate PHI to the person(s) or organization listed below as directed by the patient.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Email address: _____

Home Phone: _____ Cell Phone: _____

1) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

2) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

3) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:_____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

I understand that this consent will allow this healthcare clinician and its affiliates to use or disclose the protected health information described below. (Please check only one box).

□ Full Disclosure: Any protected health information this provider and its affiliates collect and maintain, including mental health, HIV, sexually transmitted diseases, health status, alcohol and substance abuse treatment records, and genetic testing. This also includes information on health treatment programs, plan information and caregiver resources with the person being authorized.

□ Limited Disclosure: **Identify what protected health Information is to be excluded from any disclosure.** Such as a medical condition or treatment information or a specific date range of services:

_____

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to my provider.**
- **If I cancel the consent, it will not apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**
- **Protected Health Information includes Medical, Dental, Pharmacy, Behavioral Health, Vision, and Long-Term Care.**

Individual or Legal Representative Signature _____ Date: _____

□ Individual □ Legal Representative (attach copy of authorization, ie MPOA, guardianship)