Section A: This section must be completed for all Authorizations			
Patient/Plan Member Name:	**Birth Date:**	**Social Security No. *(optional)*:**	
Provider's/Health Plan's Name:	**Requester's Name:**		
Provider's/Health Plan's Address:	**Address 1:**		
	Address 2:		
	City:	**State:**	**Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record		☐ Operative Information		☐ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Billing record:	
☐ Intake/outtake		☐ Nursing Information		☐ Other:	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise in section C.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the Requester of this PHI another health plan or health care provider?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

What is the purpose of this use or disclosure?

Will the requester receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Will the PHI be created for research and include treatment of the Patient?
If yes, complete Section C below otherwise skip to Section D.

Describe the extent to which the PHI will be used or disclosed to carry out treatment, payment or health care operations?

Describe the disclosures that will NOT be made even if they are permitted by law.

Will the Requester plan to obtain the Patient's consent and/or provide a notice of privacy practices? ☐ Yes, then all statements above are binding. ☐ No

Section D: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	**Date:**
Print Name of Patient/Plan Member's Representative:	**Relationship to Patient/Plan Member:**