Authorization to Obtain or Release Protected Health Information (PHI)

**I,_____, HEREBY AUTHORIZE CCAY TO: ☐ Obtain PHI from entity below

☐ Disclose PHI to the entity below

Patient's name: _____

Date of Birth:_____**Phone:** _____

Address:_____

Provider or facility authorized to release information:

_____

Person or entity authorized to receive information:

_____

Effective Period**

This authorization for release of information covers the period of healthcare as indicated below.

Dates of Service: ☐ All past, present and future periods.

☐ Specific Dates of Service: _____

Extent of Authorization**

Description of information: ☐ Entire Record, I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS and treatment of alcohol or drug abuse, and genetic test results).

OR

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental Health Records
- ☐ Communicable Diseases (Including AIDS/HIV)
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Genetic Test Results

Authorization

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
2. This authorization shall be in force and effect for 12 months from the date of signature, at which time this authorization expires.
3. I understand that I have the right revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Patient's Representative **Date**

Printed Name of Patient's Representative:

Relationship to the Patient:

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **