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Authorization for Release of Protected Health Information (PHI)

Patient Name _____	SSN# _____
Address _____	
City _____	State _____ Zip _____
Phone _____	DOB _____

I hereby authorize: \_\_\_\_\_

Address: \_\_\_\_\_

to release:

- Office Intake/Evaluation
- Office SOAP/Progress notes
- Hospital Discharge Summary
- Radiology reports
- Lab results
- Problem list
- Other:

I understand that this authorization gives my permission to release any PHI that is contained in my medical record unless I specifically indicate "NO" next to one or more of the categories noted below:

\_\_\_\_\_ **Substance Abuse Information** \_\_\_\_\_ **Psychiatric/Mental Information** \_\_\_\_\_ **HIV Information**

This authorization is voluntary and being made at the request of the individual.

The released PHI may no longer be protected by Federal Privacy Laws and may be re-disclosed by the individual or organization authorized to receive the PHI.

This authorization will not be used for medical underwriting. Therefore, my treatment, payments, and enrollment or eligibility for benefits will not be conditioned on my signing this authorization.

This authorization will automatically expire one year from the date signed.

I may revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

Release to:

**Polek MD, P.C.**

**Samuel Polek, M.D.**

2803 Greystone Commercial Blvd.

Suite 12

Birmingham, AL 35242

Phone: (866) 219-2688

Fax: (423) 523-0994

Signed: \_\_\_\_\_

(State relationship if not patient)

Date: \_\_\_\_\_