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# Authorization for Release of Protected Health Information (PHI)

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[www.PhoenixEmergencyCare.com](http://www.PhoenixEmergencyCare.com)

(256) 882-7469 Tel

(256) 425-0046 Fax

Phoenix Emergency Care

7105-BBailey Creek Circle, SE

Huntsville, AL 35802-2797

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

SocSecNo: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

To: \_\_\_\_\_

[Name of Physician(s) or Health Care Facility(ies)]

Date of Service (if known): \_\_\_\_\_

I hereby authorize disclosure of my Protected Health Information (PHI) to Phoenix Emergency Care, PC as follows:

- |  |                                     |   |   |
|--|-------------------------------------|---|---|
| <input type="checkbox"/> Complete Medical Records  | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Progress Notes   | <input type="checkbox"/> Consult Note     |
| <input type="checkbox"/> Inpatient Admissions      | <input type="checkbox"/> EKG/EEG    | <input type="checkbox"/> Anesthesia       | <input type="checkbox"/> L/D Birth Record |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> ED Record  | <input type="checkbox"/> X-ray Reports    | <input type="checkbox"/> Echo/GXT         |
| <input type="checkbox"/> Operative Note            | <input type="checkbox"/> MD Orders  | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Lab        |   |   |
| <input type="checkbox"/> Other _____               |                                     |   |   |

The purpose of this Release of Information is for:

- Information needed to treat patient who is in the office now.
- Information is needed for patient appointment scheduled on \_\_\_\_\_
- At the request of the patient.
- Information is needed for billing purposes.
- Other \_\_\_\_\_

I understand that my records are protected under HIPAA Regulations.

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Name

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Signature

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Date