Authorization for Release of Protected Health Information (PHI)

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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:

☐ Complete Medical Records	☐ Face Sheet	☐ Progress Notes	☐ Consult Note
☐ Inpatient Admissions	☐ EKG/EEG	☐ Anesthesia	☐ L/D Birth Record
☐ History and Physical Exam	☐ ED Record	☐ X-ray Reports	☐ Echo/GXT
☐ Operative Note	☐ MD Orders	☐ Pathology Report	☐ Physical Therapy
☐ Discharge Summary	☐ Lab		

☐ 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.

______________	______________________________	______________
Name	Signature	Date