## **Authorization for Release of Protected Health Information (PHI)**

<u>www.PhoenixEmergencyCare.co</u> (256) 882-7469 Tel (256) 425-0046 Fax Phoenix Emergency Care 7105-BBailey Creek Circle, SE Huntsville, AL 35802-2797

Name:	Birthdate:			
SocSecNo:		Telephone:		
Address:				
The undersigned hereby as disclose and furnish this repotential for this information the information disclosed governing the use and relevant of Person/Facility to	equested information to be redisonwill not be properties.	mation to the persor closed by this perso stected by applicable alth information:	n/facility below. n/facility exists e federal/state la	The and
Date of Service (if known):				
☐ Complete Medical Records ☐ Inpatient Admissions ☐ History and Physical Exam ☐ Operative Note ☐ Discharge Summary ☐Other	☐ Face Sheet ☐ EKG/EEG	☐ Anesthesia	☐ Consult Note ☐ L/D Birth Rec ☐ Echo/GXT ☐ Physical There	
If your health information that apply in order to avauthorizing the release of the Psychiatric/mental health co-signature is required foyears old) ? AIDS/related illness, diagner of the property of the prop	oid delay. By clue following infor or developmenta or the release of nosis/treatment?	necking any of these omation: Il disabilities information psychiatric information HIV test results? Generation	categories, you are n (Parent/guardian of patients 12-1' etic testing	e 1 7
The purpose of this Release of I understand that my records are				
Name	Name Signature			Date