Authorization for Release of Protected Health Information (PHI)

www.PhoenixEmergencyCare.co
(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 authorizes and requests Phoenix Emergency Care, PC to disclose and furnish this requested information to the person/facility below. The potential for this information to be redisclosed by this person/facility exists and the information disclosed will not be protected by applicable federal/state laws governing the use and release of your health information:

Name of Person/Facility to be released to:_____

Date of Service (if known):_____

☐ 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_____

If your health information contains any of the following, please check all categories that apply in order to avoid delay. By checking any of these categories, you are authorizing the release of the following information:
? Psychiatric/mental health or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)
? AIDS/related illness, diagnosis/treatment ? HIV test results ? Genetic testing
? Alcohol/drug abuse diagnosis/treatment

You must acknowledge that you are checking these categories by furnishing your initials here: _____

The purpose of this Release of Information is for _____
I understand that my records are protected under HIPAA Regulations.

_____ _____ _____
Name Signature Date