Authorization for Release of Protected Health Information (PHI)

www.PhoenixEmergencyCare.com
(256) 882-Phnx Tel
(256) 425-0046 Fax

Phoenix Emergency Care
7105-BBailey Creek Circle, SE
Huntsville, AL 35802

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_____

The purpose of this Release of Information is for _____

I understand that my records are protected under HIPAA Regulations.

I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose my medical records described in this form to the person(s) and/or organization(s) named in this form.

_____ _____ _____
Name Signature Date