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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Last Name:____________________ First Name:_________________ M.I.______ Maiden: ________________
D.O.B.:_______________________ SSN_____________________ Phone:______________________________

PCAIMA PHYSICIAN TO DISCLOSE (RELEASE) INFORMATION TO:

Name: ____
Address:____
City/State/Zip:____
Phone: _________________________________ Fax: ______________________________

Specific Information to Be Disclosed: ____
Dates of Service: ____
For the Purpose of: ____
This Authorization Will Expire On: ____

I understand that the information in my health record may include information relating to:
-- Sexually Transmitted Diseases
-- Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)
-- Behavioral, Mental Health or Psychiatric Conditions
-- Drug or alcohol abuse, drug-related and/or alcohol-related treatment

I AGREE TO SUCH RELEASE: PLEASE INITIAL AND DATE: ____

When my health information is used or disclosed pursuant to this authorization it may to be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use or disclosure of any information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the PCAIMA Office, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect, and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

Patient Signature or Patient's Representative: _____________ Witness: _________________________________

Relationship to Patient: _________________________________

Date: ____ Date:___________________________________