AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

(Please Complete All Highlighted Sections to Avoid Any Delays in Processing)

Please Print

Patient's Name: _____ **Date of Birth:** _____ **Patient #** _____
Last First Middle (MM/DD/YYYY)

Address: _____
Street City State Zip

Phone Number: _____ **E-Mail Address:** _____ **Date(s) of Service:** _____

Purpose of Release:
- □ **Continuity of Care/ Treatment**
- □ **Leaving Practice/Change of Doctor (minimum document set)**
- □ **Self/Personal Reasons (minimum document set)**
- □ **Disability (minimum document set)**
- □ **Insurance**
- □ **Employment Related**
- □ **Research**
- □ **Legal Reasons**
- □ **Other (please specify):** _____

I hereby authorize the release of my health information from the Practice/Organization named above to the Recipient named below.

Physician Practice/Organization Authorized to **Release** Information:

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

Person/Physician Practice/Organization Authorized to **Receive** Information:

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

Information to be Released – For the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all the documents listed.

□ **Complete Record**	□ **Minimum Documents** (the following will be sent)	□ **Additional Documents** (comprised of Minimum Documents plus the following selected items):
	• **Progress Notes – last 2 years** • **Radiology (if applicable) – last 2 years** • **Lab (if applicable) –last 2 years** • **Other Diagnostic Tests (if applicable)-last 2yrs** • **Cardiovascular (if applicable) – last 2 years** • **Consultations – last 2 years** • **Hospital Records – last 2 years**	□ **Physician Orders** □ **Nurses Notes** □ **Graphics** □ **Physical Therapy** □ **Medication Lists** □ **Other/Misc:** _____

Method of Release:

□ **Mail** □ **Fax** □ **Email** □ **Other (please specify):** _____

☐ **I authorize the release of records related to treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses.**

Expiration: This authorization for release of protected health information for the date(s) of service indicated is effective until _____ or for a maximum of one year from the date signed below.

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that OneGI has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to the One GI Location that released the medical records

Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Fees: The fee will depend on the number of copies requested and the current rate allowed by state law.

OneGI does not condition treatment, payment enrollment or eligibility for benefits on the signing of this authorization.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

Revised 2023.10.04