Authorization for Release of Protected Health Information

Patient Name : _____ **Date of Birth:** ____/____/____

Phone: _____

I **request that my protected health information (PHI) be** ☐ **disclosed to** ☐ **obtained from:** ☐ Disclosure to patient

Recipient Name: _____

Address: _____ City: _____ State:_____Zip: _____

E-mail Address:_____ Phone: _____

Fax: (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

☐ All Records Pertinent to Continuing Primary Care covering the period of healthcare from:_____to _____

(*Please use specific dates)*

I understand that my protected health information may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service and treatment for drug and alcohol abuse.

Or Specify:

☐ Exclude specific records (*please specify)*_____

☐ ONLY White House Clinics records

☐ Records Regarding Treatment of Specific Illness, Condition, or Injury (*please specify)*_____

☐ All Pharmacy Records

☐ Specific Records Regarding Behavioral Health Treatment: ☐ Treatment Plans ☐ Initial Eval ☐ Progress Notes

Specific Dates: _____ **Reviewed and Approved by:** _____

☐ Other: (*please specify)* _____

Purpose for Requesting Information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Other (*please specify):*

_____

Disclosure Format (Paper is default if not marked.):

☐ Paper (within 10 days) ☐ Fax ☐ Secure E-mail ☐ CD (within 3 business days) ☐ Patient Portal ☐ Other *(please specify):*

_____

By signing this authorization form, I confirm I have been made aware of the rights and conditions listed on the back of this form:

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Print Name Relationship to Patient (*if other than self)*

_____ _____

Witness Signature (*Verified by)* Witness Signature Date

☐	Richmond Location:	401 Highland Park Drive, Richmond, Kentucky 40475	Phone: (859) 626-7700	Fax: (859) 626-7703
☐	Berea Location:	104 Legacy Drive, Berea, Kentucky 40403	Phone: (859) 986-2323	Fax: (859) 986-7728
☐	Berea Primary Care Location:	305 Estill Street, Berea, Kentucky 40403	Phone: (859) 985-1415	Fax: (859) 986-6752
☐	McKee Location:	1010 Main Street South, McKee, Kentucky 40447	Phone: (606) 287-7104	Fax: (606) 287-3323
☐	Irvine Location:	30 Stacy Lane Road, Irvine, Kentucky 40336	Phone: (606) 723-0665	Fax: (606) 723-0680
☐	Mt. Vernon Location:	116 Progress Drive, Mt. Vernon, Kentucky 40456	Phone: (606) 256-2143	Fax: (606) 256-9762
☐	Paint Lick Location:	480 Main Street, Paint Lick, Kentucky 40461	Phone: (859) 925-2444	Fax: (859) 925-2334
☐	Lancaster Location:	103 Southern Soul Way, Lancaster, Kentucky 40444	Phone: (859) 792-4332	Fax: (859) 458-4038

*This is a 2-sided form

Rights and Conditions

- I am authorizing White House Clinic to disclose/obtain certain protected health information (PHI) about me to the party or parties listed above.
- I have the right to change or cancel this authorization at any time by notifying the Privacy Officer, in writing, at Health Help, Inc., Attention: Privacy Officer, 401 Highland Park Drive, Richmond, Kentucky 40475. Revocation will not apply to information that has already been disclosed in response to this authorization.
- I understand that unless otherwise revoked, this authorization will expire 1 year from date signed.
- I understand that I do not have to sign this authorization and that White House Clinic cannot condition treatment or payment on whether I sign this authorization.
- I understand that information used or disclosed based on this authorization may be subject to additional disclosure by the recipient named above and may not be protected by federal laws and regulations regarding the privacy of my protected health information. I understand that I have the right to inspect and copy the information to be disclosed.
- I understand that disclosed protected health information that is received via secure email may not be protected after opening.
- I understand that White House Clinic may receive reimbursement from the above recipient for the expense of supplies and labor necessary to disclose my personal health information.