SIMON Family Medicine
YOUR FAMILY'S DOCTOR

Authorization for Release of Protected Medical Health Information

I _____
Patient's Name (please print) DOB SS#

authorize _____ to release the following information from my Protected Medical Health Information (Medical Record).

****PLEASE PROVIDE ALL DATES OF SERVICE****

- ☐ Emergency Room Report _____
- ☐ Laboratory Reports _____
- ☐ Radiology/Diagnostic Imaging _____
- ☐ Pertinent Information _____
- ☐ Complete Medical Chart _____
- ☐ Other _____

The information is to be released to: _____
Print name of person, physician or facility

for the purpose of _____
Describe specifically what the disclosure is for

This authorization will expire two months from the date of signing.

☐ I acknowledge that I have the right to revoke the authorization at any time and that I understand that once the information is disclosed, it may no longer be protected by federal privacy law. You may revoke your authorization only in writing and the revocation will be effective upon receipt.

☐ If I am billed for my records, I am aware of the charge of $0.60 per page for photocopies.

_____ _____
Patient Signature Date

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