**Authorization for Release of Protected Health Information**

**Patient Information**

Patient Name: ______________________________________________________________________

DOB: ____________________________________ Account No: __________________________

**Authority to Release Protected Health Information**

I hereby authorize Hansbrough, Peters, Traxler & Scallan, AMA; The Hearing Center and the Allergy Center ("Provider") to release the information identified in this authorization form from the medical records of Provider and provide such information to ("Requesting Party"). **Please indicate Requesting Party's Name and Relationship to Patient below.**

_____________________________________________________________________________________

_____________________________________________________________________________________

**The following information is to be released**

A Certified Copy of the entire medical records file, including but not limited to: office notes, correspondence, existing narrative reports, x-ray films and reports, CT Scan films and reports, diagnostic films and reports, etc., hospital records, lab results, HIV test results, patient intake forms, initial application and information sheets, consultation reports, physical therapist reports, billing records, appointment records, progress notes, hand-written notes, nurses' notes, records of prescriptions, patient orders, pathology slides, insurance claim forms, or any and ALL records compiled by you in your possession pertinent to the treatment of me.

This release not only authorizes the release of tangible medical information only but also authorizes verbal communication by the health care provider to the Requesting Party.

**Purpose of the Requested Disclosure of Protected Health Information**

I am authorizing the release of my Protected Health Information for the following purposes: At the Request of the Individual (i.e., the Patient, in a minor – the Patient's Legal Guardian or Parent.

**Drug and/or Alcohol Abuse and/or Psychiatric, and/or HIV/AIDS Records Release**

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release. I further understand if my medical or billing records contains information in release to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome? Testing and/or treatment I agree to its release. **If patient does not agree, please indicate to which they are not in agreement here.** ____________________________________

**Right to Revoke Authorization**

Except to extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to Provider. Unless revoked, this authorization will expire in one year from date signed.

**Re-disclosure**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer by protected by the Health Insurance Portability and Accountability Act of 1996.

**Signature of Patient or Personal Representative Who May Request Disclosure**

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can inspect or copy this protected health information to be used or disclosed.

Signature: ______________________________ Date: __________________________
(Release expires one year from this date)

Print Name: ______________________________

Relationship to Patient: ____________________________________________________