ALISON SNIDER, MD

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Release of Information Form)

Patient Name:_____Date of Birth:_____

Address: _____City: _____State: _____Zip:_____

Telephone: _____Social Security #: _____

I hereby authorize the use or disclosure of my individual identifiable health information as described below. This includes information pertinent to mental health, drug/alcohol abuse and HIV/AIDS diagnosis. I understand that this authorization is voluntary. The information released may not be released by the recipient without my authorization. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider, the released information may no longer be protected by federal or state privacy regulations.

TO RELEASE INFORMATION TO:

Name:_____

Address:_____

City:_____State:____Zip:____

Phone:_____Fax:_____

TO OBTAIN INFORMATION FROM:

Name:_____

Address:_____

City:_____State:____Zip:____

Phone:_____Fax:_____

Information to be released/disclosed (Select from the following. Check as many as apply):

- □ Discharge summary
- □ History & physical
- □ Consultation reports
- □ Operative notes
- □ Progress/office notes
- □ Laboratory tests
- □ X-ray reports
- □ Other: _____

I understand that this authorization will expire on ____/____/____.

There may be a charge for re-production of medical records

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Authorized Representative Date

_____ _____

Witness Signature Date