Instructions to Completing the Authorization for Protected Health Information (PHI)

These instructions were designed to help answer any questions that may arise when completing the *Authorization Form for the Release of Protected Health Information*.

Section A-

Patient's Name	The name of the person who received the medical service(s).
Birth Date	The patient's date of birth.
Patient's Phone	A phone number where the patient may be reached.
Social Security Number	Last four digits of the patient's social security number. - ***This field is optional.***
Provider's Name	Name of the facility or hospital where the patient service was performed.
Provider's Address	Complete Mailing Address of the facility or hospital. - ***This field is optional.***
Recipient's Name	Name of the person being authorized by the patient to receive the requested protected health information.
Recipient's Phone	A phone number where the recipient of the medical information can be reached.
Recipient's Address	Complete mailing address for the designated "Recipient." Please be sure to include your zip code.
Email	Complete only if eDelivery is requested.
Request Delivery	Specify how the recipient is to receive the requested information.
Expiration Date or Event	Authorization will expire in 90 days unless otherwise noted on this form.
Purpose of Disclosure	Explain why the requested protected health information is being requested.
Psychotherapy Notes	Mark the "Yes" box if the information being requested is Psychotherapy-related. Mark the "No" box if the information is not related to Psychotherapy.
Description of Information to be Used or Disclosed	***Description***- Mark the box that best describes the type of health information requested for use or disclosure. ***Date of Service***- Provide the date of service related to when the medical treatment was rendered. If the requested information being requested pertains to an inpatient hospital stay, provide the discharge date. ***Consent to Release***- Initial this box if you acknowledge and consent to the release of protected health information that may contain alcohol/drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. Check box to the right if not applicable.

Section B-

This section need to be completed only if the request is for marketing purposes and the patient received compensation in exchange for this information. Select "Yes" or "NO". If "Yes," provide a brief explanation.

Section C-

Signature of Patient/Guardian or Personal Representative	The patient's signature is always required, unless the patient is a minor or a legal representative has been appointed.
Date Signed	Provide the date that this authorization form was signed.
Printed Name of Patient/Guardian of Personal Representative	Print the name of the individual who signed this authorization form.
Relationship of Personal Representative to Patient	If someone other than the patient signs the authorization form, a description of the representative's authority to act on behalf of the patient must be provided (i.e. Medical Power of Attorney, Executor of Estate, or Legal Guardian). Also, please include a copy of all supporting documentation (i.e. a copy of the medical power of attorney, court order for Executor of Estate, or court order for guardianship.