Authorization to Release Protected Health Information(PHI)

Patient Name:____

Address:____

Date of Birth:______________________ **Social Security#**___________________

I authorize release of medical records FROM: First Choice Emergency Room.

□ Check here if picking up records at facility, below "send to" information unnecessary

Please send requested medical records TO: ____

Address:____

Telephone Number:____

I specifically authorize ___________________________________ to obtain the following PHI:

- Complete Records
- Emergency Physician Records Date of Service_______-_______
- Lab Reports Date of Service_______-_______
- Radiology Reports Date of Service_______-_______
- Discharge Summary Date of Service_______-_______
- Other

By signing this Authorization Form, I understand that I am giving my authorization for ________________________________ to receive all protected health information (PHI) relating to m diagnosis, testing or treatment. I may revoke this authorization at any time by notifying First Choice Emergency Room of my intent to revoke this authorization. This authorization is voluntary and will expire on the 180th day of signing.

____ ________
Signature of Patient or Authorized Personal Representative Date

____
Relationship to the Patient (If signed by a Personal Representative)