

## Medical Record Release of Protected Health Information (PHI) From CAAC

I authorize the use/disclosure of health information about \_\_\_\_\_  
 (Patient Name and date of birth)

as described below:

1. Name and address of party to receive information:

\_\_\_\_\_

\_\_\_\_\_

2. Description of information that may be used/disclosed ( Be specific – either entire health record (chart) or specific parts i.e. progress notes, testing results, lab results, etc)

\_\_\_\_\_

\_\_\_\_\_

3. The information will be used/disclosed for the following purposes: Check one

- Transfer of care     Insurance company review  
 Other – specify \_\_\_\_\_

4. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization.

This authorization expires on \_\_\_\_\_. **(Must be filled in)**  
 (Date) day/month/year    **Expiration date is for no greater than a year**

7. I understand there may be a reasonable fee applied for records copied.

\_\_\_\_\_  
 Signature of Patient or Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Patient's Name (print)

\_\_\_\_\_  
 Date of Birth