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