Ennis Endocrinology Clinic

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Authorization to Disclose Protected Health Information (PHI)

This form is optional
If you would like to allow certain entities/individuals to have access to your protected health information (PHI)

Print Name _____ **Date of Birth:** _____/_____/_____

I authorize the use and/or disclosure of Protected Health Information (*PHI*) as described below.

- Name of Organization(s) authorized to use, release or disclose the Protected Health Information:

  _____

- Name of person(s) authorized to receive Protected Health Information:

  _____ Relation: _____

  Phone Number: _____

  _____ Relation: _____

  Phone Number: _____

- I allow the disclosure of Protected Health Information to be left on my voicemail, in the event that I am not available:

  Phone Number: _____ Cell Home Work Other *(circle one)*

The information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, HIV test results, developmental disabilities, and genetic testing results **unless I give written instructions not to release such information.**

I have the right to cancel or revoke this authorization at any time. If I want to cancel this authorization, I must do so in writing and present it to the clinic. I understand that the cancellation (revocation) may not apply to information that has already been released.

I have a right to inspect and/or receive a copy of the Health Information to be released and that I may be charged for any copies of the records that I receive. Access to health information created or obtained may be temporarily suspended until the chart note/review has been completed. Once completed, I will again have access to my health information.

If no prior notice to revoke this authorization is received, this authorization will expire on (select one):

☐ _____ Year(s) ☐ _____ (enter specific date)

The information disclosed may be re-disclosed by the recipient and may no longer be protected by the Federal privacy rules.

If additional Health Information is required other than what has been identified above, another authorization form must be completed and signed.

_____ _____

Signature of Patient/Legal Representative **Date/Time**