

# **INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)**

**The following are instructions for the completion of an Authorization for Use or Disclosure of Protected Health Information (PHI)**

## **SECTION A - Demographic:**

Provide the patients' information. This section must be completed in **full** for all authorizations.

### Type of Delivery:

Indicate your delivery preference. You will receive a paper copy of your records if this section is left blank. You may select electronic media (e.g., USB drive, CD/DVD) encrypted or unencrypted email. You must provide your email address to receive records via email.

### Expiration:

This authorization will expire 180 days after the date it is signed. You may fill in a different date or event but not both.

### Purpose of Disclosure:

Indicate the purpose of your request for medical record copies (e.g., personal, continued care, insurance payment, etc.)

### Description of Information to be Used or Disclosed:

Check the type of information you would like to use or disclose. "All PHI in medical record" will include physician reports and test results. If you would like a complete copy of your records, check "All PHI" and add "complete records" next to it.

Facility: Check the name of the hospital disclosing your information.

Acknowledge your records may contain sensitive information.

## **SECTION B:**

Tell us if your request for PHI (medical records) is for marketing and/or it involves the sale of PHI.

## **SECTION C:**

Sign and date the authorization.

You may call 1-888-749-7952 for questions or additional information for releasing your medical records.