

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) & MEDICAL RECORDS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Practice Name & Address: \_\_\_\_\_

**Information to be Used or Disclosed:**

- My dental information relating to the following treatment or condition: \_\_\_\_\_
- Most recent \_\_\_\_\_ years of record
- My dental records for the following date(s): \_\_\_\_\_
- Entire dental record:
  - Include  Exclude: My health information related to Substance Use Disorder *including diagnosis, referral, treatment records, etc.*
  - Include  Exclude: My health information related to HIV/AIDS
  - Include  Exclude: My health information related to Psychotherapy records

**Receipt of Information:**

Name/Organization \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Email/Fax \_\_\_\_\_

**Purpose of Use or Disclosure:**

- Treatment, payment, or health care operations
- Other (describe in detail): \_\_\_\_\_

This authorization will terminate:  On the following date: \_\_\_\_\_ or  One (1) year from date of signature

I authorize Ronald H Ellingsen, PLLC to release my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Representative Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_