

Authorization for Release of Protected Health Information

Campbell & Philbin Medical Associates

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Patient Name: _____

Date of Birth: _____

I have been a patient of _____ (or am the patient's authorized representative).
(Doctor, Clinic, or Hospital Name)

I understand _____ has legally protected health information about me, or the person I represent.
(Doctor, Clinic, or Hospital Name)

I, _____ hereby authorize _____ to release to:
(Your Name) (Doctor, Clinic, or Hospital Name)

Campbell & Philbin Medical Associates, copies of the following:

- _____ Progress Notes
- _____ Entire clinical chart including HIV-related information
- _____ Entire clinical chart including mental health, drug or alcohol treatment
- _____ Entire clinical chart excluding HIV-related, mental health, drug or alcohol treatment
- _____ Other (please specify) _____

from (date): _____ to (date): _____

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. I understand that I have the right to revoke this authorization at any time by sending a written consent to the entity/person I authorized above to release the information.

Although applicable law may prohibit re-disclosure of these records I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) Campbell & Philbin Medical Associates and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule.

My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of claim.

Campbell & Philbin Medical Associates cannot require me to sign the Authorization in order to receive treatment.

Patient or Representative Signature Date Witness Date

If representative, give relationship: _____