

## Request to Send Protected Health Information TO and FROM a Third Party

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

-I request that **Ira Phillips, MD**, his staff, and/or coverage providers to send a copy of my protected health information (PHI) and/or communicate about my health care to the following entity.

-I also authorize the following entity to send a copy of my protected health information (PHI) and/or communicate about my health care to Ira Phillips, MD, his staff, and coverage providers.

**-The purpose of release is for ongoing evaluation and treatment.**

Name of Third Party: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

### Description of Protected Health Information to be disclosed:

All healthcare information including psychological/psychotherapy notes.

Specific Information: \_\_\_\_\_

-and-

All dates of service

Specific Dates: \_\_\_\_\_

Or to limit information

Healthcare information relating to the following treatment, condition, or dates of service with limitations (if any) and any other concerns:

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drugs and/or alcohol abuse, and acquired immune deficiency syndrome (AIDS) and/or HIV status.**

\_\_\_\_ (initial only one) I **understand** and **DO authorize** this information to be released.

\_\_\_\_ (initial only one) I **understand** and **DO NOT authorize** this information to be released.

-I understand protected health information will not be disclosed to a third party without my written authorization, except as allowed by law. I understand that my protected health information disclosed by this release may be subject to redisclosure by the recipient and no longer protected by law. Ira Phillips, MD, is not responsible for any changes made on his medical record copies once released.

-I understand this authorization may be revoked with a written statement at any time, except to the extent that action has already been taken in reliance on this authorization.

-Unless otherwise noted, this authorization will expire in one year. Other expiration date: \_\_\_\_\_.

-I understand that Ira Phillips, MD, will not condition treatment on my signing of this release.

-I understand that I have a right to a copy of this authorization after signing it.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Representative (if applicable): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

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DISCLAIMER: The document and anything accompanying it may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any use, disclosure, copying, or distribution, is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.