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 if 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 understanding 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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