

**COLLETON AMBULATORY SURGERY CENTER**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

**Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient?** If yes, complete the Authorization for Research Form. If no, proceed to Section B.

**Section B: Required for all Authorizations for Release of PHI or Right to Access**

Patient Name:		Birth Date:	Social Security No. (optional):
Patient's Address:		Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Address/City/State/Zip	Phone Number: ( ) _____	Fax Number: ( ) _____
PHI Sender Name:	Address/City/State/Zip	Phone Number: ( ) _____	Fax Number: ( ) _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: \_\_\_\_\_ Event: \_\_\_\_\_

Purpose of Disclosure:

Is this request for psychotherapy notes?

- Yes, then this is the only item you may request on this authorization.  
 No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record		<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Demographics	
<input type="checkbox"/> History and Physical		<input type="checkbox"/> Laboratory		<input type="checkbox"/> Rehabilitation	
<input type="checkbox"/> Consult Report		<input type="checkbox"/> Imaging/Radiology		Services	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Nursing Notes		<input type="checkbox"/> Special Test/Therapy	
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Medication Record		<input type="checkbox"/> Itemized Bill/Claims	
				<input type="checkbox"/> Other:	

- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ (Initial)
- I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I will receive a copy of this form after I sign it.

**Section C: Signatures**

**I have read the above and authorize the disclosure of the protected health information as stated.**

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: