Received by: _____
(staff initials)

Plastic + Hand
SURGICAL ASSOCIATES

Authorization to Release Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Release information from:	**Release information To:**
Name/Facility: _____	**Name/Facility:** _____
Address: _____	**Address:** _____
Phone/Fax: _____	**Phone/Fax:** _____

Reason for release

Continuity of Care	❑	Military	❑
Personal Records	❑	Long term disability	❑
Legal	❑	Other: _____	
Claims or billing	❑		

Information to be released:

		Billing records	❑
Records within 1 year	❑	Imaging reports and photographs	❑
Records within 3 years	❑	Surgical and Operative reports	❑
Records within 5 years	❑	Consult notes	❑
*Records older than 5 years	❑	Lab results	❑
*Please allow up to 14 days for records to be released.		Other: _____	

Please check boxes below to allow or decline release of sensitive information:

Mental Health records	❑	Yes	❑	No
HIV/STD status	❑	Yes	❑	No
Substance Abuse Records	❑	Yes	❑	No

By signing below I authorize to release records as outlined above. This authorization is effective until I, or the signed authorized representative provides written revocation of this authorization. Otherwise, this release expires 30 months after signed. I understand that PHI released pursuant to this authorization may include records generated by another healthcare facility. I authorize future uses and disclosures regarding these records to the same individuals or entities during this time period. I acknowledge that I can have a copy of this form upon request and can discontinue disclosure at any time.

Patient or legal guardian signature: _____ Date: _____

Received by: _____
(staff initials)

—