AUTHORIZATION FOR RELEASE/OBTAIN OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Release/Obtain Information

Release to/Obtain From: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Purpose of Release/Obtain

☐ Person ☐ Legal/Attorney ☐ Insurance ☐ Disability ☐ Continuing Care ☐ School

☐ Worker's Compensation ☐ Other (be specific): _____

PHI to be Released/Obtained

Format for Release: ☐ Paper ☐ Electronic ☐ View Access as scheduled

Service Dates: From: _____ To: _____ **Information Needed by (optional):** _____

☐ History	☐ Radiology Reports	☐ Occupational Therapy Notes
☐ Operative Report	☐ Radiology Images	☐ Dental Records
☐ Progress Notes	☐ ER Report	☐ Entire Medical Record
☐ Discharge Summary	☐ Immunization Record	(does not include images)
☐ Laboratory ReportsPhysical	☐ Therapy Notes	
☐ Other:		

Sensitive Information Release: I understand that this health information may include sensitive information. By signing this form, I specifically authorize the release of each sensitive information.

This authorization will expire 1 year from the date of signature. I understand that when I give my permission to release my health information or take my permission away from another facility or person, I must contact that party. I understand that to revoke my authorization, I must send a signed, written notice to: GetWell Internal Medicine, Attn: Office Manager, 5221 Getwell Road, Suite A, Southaven, MS 38672. The notice should include detailed information as identified in the original authorization request. I understand this form is voluntary, and Getwell Internal Medicine will not condition my treatment on giving this authorization. I understand that I am entitled to receive a copy of this form after I sign it. I have carefully read and understand the Patient's Rights above and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization, including the "Sensitive information Release". I acknowledge this authorization with my signature below.

Patient (or Guardian) Signature: _____ Date: _____