Buckeye Medical, Inc.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No.** ***(optional):***
Telephone Number for Contact:	**Mode of Release:** ⌷ **Mail** ⌷ **Pick-Up** **Date Needed:** ________	
Release Information To:	**From:**	**Phone:**
	Address :	
	City:	**State:** **Zip:**

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

Purpose of disclosure:

Description of Information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ Complete medical record ☐ Operative Report ☐ Discharge Summary ☐ Laboratory ☐ Radiology ☐ Progress Notes ☐ Medication Sheets		☐ Consultation Notes ☐ Work Related Injury Notes ☐ Employer Requested Drug Screens ☐ Itemized Bill ☐ Other		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) If not applicable, check here. ⌷

I understand that:

1. If the person or entity that receives the above information is not a health care provider or health plan, the information may be redisclosed and will likely no longer be protected by the federal privacy regulations.
2. As described in the Notice of Privacy Practices of Bellevue Professional Services, I may revoke this authorization at any time in writing, except to the extent that action has been taken by Bellevue Professional Services in reliance on this authorization.
3. I understand that I am not required to sign this authorization form and that Bellevue Professional Services will not condition the provision of treatment or payment to me on the signing of this authorization..
4. 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.
5. I understand that I may have a copy of this authorization if I so request.

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

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