



## Authorization for Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Proliance may disclose health information from:

Name of clinic or provider: \_\_\_\_\_

### Proliance may disclose the following health information:

- ☐ Current medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc within the last 12 months)
- ☐ All medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc)
- ☐ Health care information in my medical record related to the following treatment/condition: \_\_\_\_\_
- ☐ Health care information in my medical record for the date(s): \_\_\_\_\_
- ☐ X-ray images
- ☐ MRI images
- ☐ Billing records

### Proliance may disclose health care information regarding testing, diagnosis, and treatment for the following:

- ☐ HIV (AIDs virus)
- ☐ Sexually transmitted disease
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

### Proliance may disclose this health care information to: ☐ Myself ☐ Provider ☐ Insurance ☐ Other

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Preferred delivery method:

- ☐ Print
- ☐ Fax
- ☐ Secure Email
- ☐ Electronic Media (CD/Flash Drive)

### Reasons for this authorization:

- ☐ Personal Use
- ☐ Other: \_\_\_\_\_

### This authorization expires: (This authorization will expire in ninety (90) days after date signed unless the below is specified)

☐ On date: \_\_\_\_\_

☐ When the following event occurs: \_\_\_\_\_

☐ I understand that Proliance operates multiple clinics and facilities and I want records released from all Proliance centers.

**My Rights** – I understand that I do not have to sign this Authorization in order to get health care treatment or benefits. I must sign this Authorization to release my health care information to a third party, including another medical provider. I understand that I may revoke this Authorization by completing a Revocation of Authorization to Release Health Information, which is available in my provider's office, or by writing a letter to my provider. If I revoke my Authorization, it would not affect any actions previously taken by Proliance Surgeons, Inc., P.S. based upon this Authorization. I may not be able to revoke this Authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of patient and Relationship