AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION ("PHI")

Patient Identification

Printed Name:____ Date of Birth:_____________________

Address: _______________________________________ City:_______________ State: ________ Zip: ________

Telephone: _____________________________________

Information To Be Released by Ranken Jordan to another entity

Please check type of information to be released:

___Discharge Summaries	___Psychotherapy notes	___Diagnosis & treatment codes
___History and physical exam	___Laboratory reports	___Complete billing record/itemized bill
___Initial Evaluations/Assessments	___Pathology reports	___Complete medical record
___Progress Notes	___Diagnostic imaging reports	___Other (specify):
___Nurse's Notes	___Operative reports	

Information To Be Requested by Ranken Jordan from another entity

Please check type of information to be requested:

___Discharge Summaries	___Psychotherapy notes
___History and physical exam	___Multidisciplinary Evaluation Results
___Initial Evaluations/Assessments	___Single-disciplinary Evaluation Results
___Progress Reports	___Treatment Plans / Recommendations
___Current IEP, IHP, IFSP	___Developmental Records
___Other (specify):	

Date(s) of service of records to be released / requested: All dates of service unless otherwise specified below:

____

Purpose of Disclosure

☐ Describe Purpose:____

☐ At Request of the Individual (Check here if patient is requesting the release and elects not to provide the purpose)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

To the extent my medical/billing record contains information about drug and/or alcohol abuse, mental health/psychiatric care, sexually transmitted diseases, Hepatitis B & C testing, and/or other sensitive information, I agree to the release of this information. ***(please initial)*** ____**Yes** _____ **No**

To the extent my medical or billing record contains information about HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to the release of this information. ***(please initial)*** ____**Yes** ____**No**

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Patient Label

Person/Entity Authorized to Receive PHI	Person/Entity Authorized to Release PHI
Name:________________________	Name:________________________
Address:______________________	Address:______________________
Name:________________________	Name:________________________
Address:______________________	Address:______________________
Name:________________________	Name:________________________
Address:______________________	Address:______________________
Name:________________________	Name:________________________
Address:______________________	Address:______________________

Revocation/Expiration of Authorization

I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the Privacy Officer of Ranken Jordan at 11365 Dorsett Road, Maryland Heights, MO 63043, and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.

Unless earlier revoked, this Authorization will expire **one year** from the date of the signature below, unless otherwise specified here: ____

Re-disclosure

I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.

Signature of Patient/Parent/Legal Guardian Who May Request Disclosure

I understand that I do not have to sign this Authorization and that my treatment, payment for services, enrollment or eligibility for benefits may not be conditioned on signing the Authorization unless treatment is solely for the purpose of providing protected health information to a third party.

I hereby authorize the use and/or disclosure of the protected health information as specified above.

______________________________ ______________________________
Signature of Patient/Parent/Legal Guardian Date

If this Authorization is signed by the patient's personal representative, describe such representative's authority to act on behalf of the patient: ____

For Office Use Only

Date Authorization Received: ______________________________

Identity of Patient Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify

Name of Person Verifying Identity of Patient: ______________________________

Request fulfilled ________ (initials) ****Request to be fulfilled _________**

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