

**Authorization/Release for Protected Health Information (PHI)
Records Furnished by CCI**

Patient Legal Name	Date of Birth	SSN
Address	Phone#	
City	State	Zip Code

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above

From: Name/Title _____ Address _____ Phone # _____	To: Name/Title _____ Address _____ Phone # _____
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Reason to Release Protected Health Information _____

Type of Access Requested: _____ Specific Date Range Requested: _____

<input type="radio"/> Copies of Records <input type="radio"/> Inspection of the record	<input type="radio"/> Entire Record <input type="radio"/> Pertinent info only <input type="radio"/> ER Records <input type="radio"/> History & Physical <input type="radio"/> Consult Report <input type="radio"/> Operative Report <input type="radio"/> Rehabilitation Services	<input type="radio"/> Lab <input type="radio"/> Imaging/Radiology <input type="radio"/> Cardiac Studies <input type="radio"/> Demographics <input type="radio"/> Nursing Notes <input type="radio"/> Medication Record	<input type="radio"/> Progress Notes <input type="radio"/> Physicians Orders <input type="radio"/> Billing Records <input type="radio"/> Immunizations <input type="radio"/> Other
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Expiration: This authorization shall expire upon (check one):
 Fulfillment of this request
 Date _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
 I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
 The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
 I understand that there may be a fee involved with the fulfillment of this request. **See fee schedule below.**
 I understand that the term Complete Chart for release of Protected Health Information mean that **only records generated by this facility will be released.**
 I have read the above and authorize the disclosure of the protected health information.

Date _____
 Signature of Patient/Parent/LegalGuardian _____

Fee Schedule

Fees for duplication of Protected Health Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed \$14.00 for the first ten or fewer pages, \$.50 per page for pages 11-40, and \$.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any may be charged.

*** To ensure timely processing of medical records, please fill authorization out completely.**