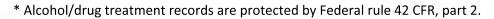


RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Request to release health informati	on of:	
Patient Name:	MRN:	EMPI#
Current	•	•
Address:	City	State Zip
Social Security Number	Phone Number () Date of Birth / /
This is to release health information	n to (if other than the patient	
☐ Personal Representative		
☐ Hospital - Receiving Facil	lity	
	ing Clinic	
☐ Other; specify:		
Name:		
Address:	City	State Zip
The purpose of this disclosure is:		
☐ Patient Request		
☐ Treatment		
☐ Payment purposes		
☐ Other; specify:		
Disclosure Method:		
☐ Verbal		
	Fax Nu	mber
Copies		
□ DVD		
☐ Mail		
Dates of service:		
Release the following information:	- 4/ >	
	Emergency record(s)	☐ Mental Health Therapy record(s)
	Pathology report (s)	☐ Treatment Plan(s)
7 7	Radiology report(s)	☐ Alcoholic/Drug Treatment record(s
,	Lab report(s)	☐ Specific Visit Record(s)☐ Other records as specified:
☐ Progress notes ☐ (Cardiology report(s)	Other records as specified:
Verification:		
☐ Photo ID#		
☐ Return phone call to		
☐ Other		
Person releasing information		Date:
(First & Last Name)		
Releasing Facility:		Department:





(Internal Use Only)