



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