DeSantis Family Practice, PLLC

Authorization for Release of Protected Health Information (PHI)

Name of Patient: _____ Date of Birth: _____

DeSantis Family Practice is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Info	Name	Phone #
Voice Mail		
Spouse		
Parent(s)		
Child 1		
Child 2		
Friend		

Description of Information to be Released (check boxes approved to receive PHI)

	Voice Mail	Spouse	Parent	Child 1	Child 2	Friend
Results of Labs/X-rays	☐	☐	☐	☐	☐	☐
Medical Information	☐	☐	☐	☐	☐	☐
Financial Information	☐	☐	☐	☐	☐	☐

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

_____ _____

Signature of Patient or Personal Representative Date