



550 30<sup>th</sup> Ave Ste 12, Moline Il. 61265

Phone: 309-762-5513 Fax:309-762-5519

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I authorize the use and disclosure of my protected health information as described below.

***Make sure ALL blanks are filled in. Failure to do so could prevent or delay processing.***

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ PREVIOUS NAME (if applicable): \_\_\_\_\_

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

**PROVIDER RELEASING THE INFORMATION:**

The following individual or organization is authorized to release my protected health information:

NAME OF INDIVIDUAL(S): \_\_\_\_\_

PROVIDER(S) OR ORGANIZATION(S): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**REQUESTOR (WHERE THE INFORMATION IS BEING SENT):**

The following individual or organization is authorized to release my protected health information:

NAME OF INDIVIDUAL(S): \_\_\_\_\_

PROVIDER(S) OR ORGANIZATION(S): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**INFORMATION REQUESTED:**

Service Dates: \_\_\_\_\_

\_\_\_\_\_ Complete records for the date above or:

\_\_\_\_\_ Lab data (dates): \_\_\_\_\_

\_\_\_\_\_ EKG data (dates): \_\_\_\_\_

\_\_\_\_\_ Progress Note data (dates): \_\_\_\_\_

\_\_\_\_\_ Imaging data (dates): \_\_\_\_\_

\_\_\_\_\_ Consultation data (dates): \_\_\_\_\_

**PLEASE SEE THE REVERSE SIDE OF FORM FOR COMPLETION**



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I authorize the use and disclosure of my protected health information as described below.

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW:**

**I specifically authorize the release of information relating to (indicate YES or NO for each):**

- \_\_\_\_\_ Substance Abuse (Drug/Alcohol)
- \_\_\_\_\_ Mental Health (includes psychological testing/visits)
- \_\_\_\_\_ Sexually Transmitted Infections (HIV/AIDS related testing/notes)

**PURPOSE OF RELEASE:**

**My protected health information will be used or disclosed for the following purpose(s):**

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*(Describe the reason for each use and disclosure of protected health information. If you do not wish to describe the purpose, you may indicate "at the request of the individual".*

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to **ADE MEDICAL GROUP** and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that already has been used or disclosed, relying on this authorization.

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**This authorization expires: \_\_\_\_\_, (list expiration date or event)**

This authorization will expire in one year from signature date if no expiration date or event is listed.

**Signature of Patient or Representative\*:** \_\_\_\_\_

**Print Name of Patient or Representative\*:** \_\_\_\_\_

**Description of Personal Representative's Authority\*:** \_\_\_\_\_

\*This form should be signed by the patient. If the patient is unable to sign a Personal Representative may sign on their behalf if the representative has the appropriate authority. A copy of any such paperwork granting such authority should also be submitted.

<b>Ade Medical Group Staff Signature:</b> _____	<b>Date:</b> _____
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