GREENLAKE PRIMARY CARE

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Section A: This section must be completed for all authorizations.				
Patient's Name:	Date of Birth:	Patient's Phone:	Last 4 digits of SSN (Optional):	
Recipient's Name:	Recipient's Address:			
Recipient's Phone:		Recipient's Fax:		
Recipient's Email:		Copy Format (select one)		
		☐ Encrypted Digital File	☐ Fax	☐ Paper
This authorization will expire upon either of the following:		Exp. Date:	Exp. Event:	

Section B: Description of Information to be Disclosed			
☐ ALL MEDICAL RECORDS **Note**: a request for all records may incur an additional fee. If you only require specific information, please indicate so below.			
☐ Admission Form	☐ Discharge	☐ Operative Info	☐ Transfer Forms
☐ Billing Records	☐ Intake	☐ Physician Notes	☐ Other:
☐ Clinical Test	☐ Labs	☐ Physician Orders	☐ Other:
☐ Dictation Reports	☐ Medication Lists	☐ Therapies	☐ Other:

Section C: Purpose of Disclosure		
Stated Purpose:		
Is the request marketing or does it involve the sale of PHI?	☐ Yes	☐ No

Section D: Acknowledgements

I understand that:

1) This authorization is strictly voluntary and I can refuse to sign it.
2) My continued treatment is not conditioned upon signing this authorization.
3) I can revoke this authorization anytime in writing, but if I do, it will not have any effect on prior releases of information.
4) If the Recipient is not a healthcare provider or plan, the information may no longer be protected by federal law and may be re-disclosed.
5) We are not responsible for unauthorized access to your PHI, or any other risks associated with this request.
6) I understand that processing this request incurs a fee and I agree to pay it. If we are unable to accommodate your requested format, we will provide an alternative delivery method and additional fees may apply.
7) I can keep a copy of this form for my records after I sign it.
8) **Sensitive PHI Disclosure Authorization**: I acknowledge that the released information may contain alcohol, drug abuse, genetic information, HIV/AIDS, and/or psychiatric information; I hereby consent to the release of such information. **(initials)** _____

Section E: Signatures

I have read and understand the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	Date:
Name of Representative:	Relationship to Patient: