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Request to Release, Copy, or Inspect Protected Health Information. HIPPA - Form B

Patient Name:_____ **Date of Birth:**_____

Address:_____ **Phone:**_____

City,State,Zip:_____ **Chart#:**_____

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information about me/my child.

This authorization permits:

_____ to use or disclose to _____
Providers Name

_____
Address

_____
City, State, ZIP

_____
Phone/Fax

Information to be Released/Copied:

( ) Day Sheets-dates:_____ ( ) Lab Info-dates:_____ ( ) Other:_____

**** BE SURE TO REVIEW ANY RESTRICTIONS PRIOR TO COPYING/RELEASING****

Reason for Record Release or Copy: ( ) Personal Copy ( ) Over Age 21 ( ) Insurance Change

( ) Moving/Changing Providers ( ) Referral to Specialist ( ) Other_____

_____ _____
Signature of patient or Legal Guardian Date

FOR INTERNAL PURPOSES ONLY:

_____
Name and Title of person releasing records

Method or Transfer: Mailed on (date):_____ Certified? (certification #):_____

Faxed to (number):_____ on (date):_____

Picked up by (name):_____ on (date):_____