Hitchcock Health Institute

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Authorization for *Hitchcock Health Institute* to "REQUEST" protected health information

Patient's Name: _____ DOB: _____

Phone Number: _____

I hereby authorize *Hitchcock Health Institute* to "**Request"** my protected health information from the following organization(s) and/or person(s).

Doctor or Facility Name: _____

Address: _____

Phone: _____ **Fax:** _____

I authorize the following information to be released: **(Please circle one)**

Entire Records Last 5 Years

Purpose of requested disclosure: (please initial one)

_____ At the request of the patient

_____ Other (Continuing care of the patient)

I understand I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Privacy officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI and have acted in reliance upon this authorization. I understand I do not have to sign this authorization and that HHI may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive this information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations. I agree that a copy of this authorization or fax of this release shall be valid as the original release. If I authorize Hitchcock Health Institute to fax information, I realize there are inherent risks in faxing protected health information; I understand a fee will be charged to cover costs of copying, including costs of supplies and labor of copying and mailing protected health information released to anyone other than another health care provider. I understand I may receive a copy of this form after I sign it.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Printed name of Patient **Relationship to Patient**