Poehailos, Dupont & Associates, PLC

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AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Use and/or Disclosure of Medical Records

RELEASE AND EXCHANGE OF INFORMATION FOR

Patient Name: _____
Date of Birth: _____
Parent/Guardian: _____
Address: _____
_____

*I give my authorization to **Poehailos, Dupont, & Associates, PLC**, to use or disclose my protected health information as described below. I give this authorization voluntarily.*

Name: _____
Organization: _____
Address: _____
Phone: _____
Fax: _____

Purpose of Request: _____

Information to be Disclosed:

- o All Medical Records
- o Psychological Evaluations/Records
- o Educational Records
- o Immunization Records
- o Laboratory Reports
- o Other: _____

PATIENT (OR PARENT/GUARDIAN) SIGNATURE

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire 1 year from the date signed below unless revoked earlier. I understand that I my revoke this authorization by notifying Poehailos, Dupont, & Associates, PLC, in writing, knowing that the previously disclosed information would not be subject to my revoke request.

Patient Signature _____ Date_____
(if under 18, Parent/Guardian Signature)

Witness Signature _____ Date_____