Authorization for Disclosure of Protected Health Information

Patient Name:	**Patient Date of Birth:**
Patient Address:	

Applies to family members or other individuals specified by the patient.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Christian Health Service of Syracuse may not use or disclose information, except as provided in our Notice of Privacy Practices, without your authorization.

☐ I do not wish to release my health information to anyone at this time.

☐ Release my health information to the following members of my family or individuals specified by me.

Authorization is granted to the listed individuals:

~Name: ____________________________________Relationship to Patient: ___________ Phone #: ________________

~Name: ____________________________________Relationship to Patient: ___________ Phone #: ________________

~Name: ____________________________________Relationship to Patient: ___________ Phone #: ________________

Description of healthcare information to be released: ☐All

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Leave Appointment Messages:	**Leave Other Medical Information:**
☐ Home phone (including auto call)	☐ Home phone (including auto call)
☐ Mobile phone (including auto call)	☐ Mobile phone (including auto call)
☐ Mobile text (including auto call)	☐ Mobile text (including auto call)
☐ Work phone	☐ Work phone
☐ With another person	☐ With another person
☐ Via mail	☐Via mail
☐ Via email/portal	☐ Via email/portal

☐ Patient received HIPAA Privacy Statement.

☐ I give permission for Christian Health Service of Syracuse to import my medication history from pharmacy databases, when available.

Expiration date of this authorization: ____________________________

(This authorization expires upon release of requested information, unless otherwise stated.)

Signature: **Date:**

Print Name: **Date of Birth:**