Philip A. Gelacek, M.D. & Associates, PC

FAMILY PRACTICE • INTERNAL MEDICINE • GERIATRICS

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

IMPRINT PATIENT IDENTIFICATION HERE

I authorize _____ to release information from the record of:
Name of Facility/Person

_____ _____ _____ to
Patient Name Birth Date SSN/MR#

_____ ( ) _____ ( ) _____
Name of Facility/Person Phone Fax

_____
Facility/Person Address

for the purpose of **(PROVIDE A DETAILED DESCRIPTION)**: _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Type of records to be released and approximate date(s) of service (check all that apply):
   - ☐ Inpatient ☐ Emergency Dept. Dates: _____
   - ☐ Outpatient ☐ Physician Office/Clinic

I authorize the release of: (check all that apply) ☐ **Mental Health Information** ☐ **Drug and Alcohol Information, contained in the records indicated above.**

2. Specific information to be released (check all that apply):
   - ☐ Consults ☐ Medical History & Physical Exam ☐ Physician Orders
   - ☐ Discharge Summary/Instructions ☐ Medication Records ☐ Progress Notes
   - ☐ Laboratory Reports/Tests ☐ Operative Report ☐ Psychiatric/Psychological Eval
   - ☐ Mammography Report ☐ Pathology Report ☐ Radiology Report
   - ☐ Emergency Dept. Report ☐ EKG Report(s)
   - ☐ Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ **Do not release**

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. See side two of this form for additional patient rights and responsibilities. If applicable, specify other expiration date/event here: _____

Date/Time of Signature	Signature of Patient (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent.)	Date/Time of Signature	Signature of Parent, Legal Guardian or Authorized Representative* (complete below)
Date/Time of Signature	Witness/Staff Member Signature		

***Authorized Representative's relationship and authority to act on behalf of patient:** _____

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date/Time	Witness #1	Date/Time	Witness # 2