

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I. Name _____ DOB _____

II. Please check and provide the requested information:

_____ I hereby authorize Monte W. Davenport, Ph.D, to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name _____

Address _____

Phone Number: _____ Fax Number: _____

_____ I hereby authorize _____ to disclose Protected Health Information to Monte W. Davenport, Ph.D.
(Primary Care Physician or other Health Care Provider)

III. I authorize the following information to be disclosed:

CHECK DATE(S)
ONE

_____ Complete Medical Record, including records from other providers and immunizations

_____ Information Relating to _____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

_____ At my request. _____
(patient's initials)

_____ Other _____
(State specific purpose of requested disclosure)

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided Monte W. Davenport, Ph.D. and Associates, PLLC. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my minor child's Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Monte W. Davenport, Ph.D. and Associates, PLLC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the 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 release or fax of this release shall be as valid as this original release. If I authorize Monte W. Davenport, Ph.D. and Associates, PLLC to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

This authorization expires upon _____

Signature

Date

Printed Name