MONTE W. DAVENPORT, PH.D.

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) via mail, phone, fax, or email.

Name _____

Address_____

Phone Number: _____ Fax Number: _____

Email Address:_____

_____ I hereby authorize the above named organization(s) and/or individual(s) to disclose Protected Health Information to Monte W. Davenport, Ph.D.

III. I authorize the following information to be disclosed:

CHECK ONE

_____ Complete Medical Record excluding records from other providers.

_____ 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 the 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 at the address below. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information, and I 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 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 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 provided and a fax or email of this release shall be as valid as this original release. I authorize Monte W.Davenport, Ph.D. and Associates, PLLC to fax or email the information requested, and I realize there are inherent risks in faxing and emailing Protected Health Information. I understand that a fee may 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_____(date)

_____ _____
Signature Date

_____
Printed Name

8/2010, 10/2020

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