AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
-Request for Healthcare Records

I, _____, (DOB: _____) hereby authorize
(Client's or Legal Representative's Name) (Date of Birth)

_____ to release the
(Person or facility name which has information)

following protected medical and/or behavioral health information (initial **one**) on paper, digitally or electronically to the PANG Collaborative PLLC for use in reviewing, coordinating and advocating on behalf of my medical and/or behavioral healthcare:

_____ **Full disclosure**. Release of any medical and/or behavioral protected health information including but not limited to physician notes, nursing notes, vitals, input/outputs, labs, tests, medication lists, medication administration record, case management and social work notes, discharge planning, etc.

_____ **Limited disclosure**. You specify what PHI to share (i.e. a specific date of service or date range, condition or treatment information, a specific procedure, etc.) Please indicate here what PHI you would like released from the entity named above: _____
_____
_____
_____

I understand that by signing this authorization:

- This authorization shall expire on ____/____/____ or until revoked by me in writing, whichever comes first. (date)
- I understand that this authorization may be updated at any time, and the updated authorization will replace any pre-dated authorization. Hence, the most currently dated authorization will be the one used to release and disclose PHI pursuant to this authorization.
- I authorize the entity named above to release my protected medical and/or behavioral health information as indicated in my choices above.
- I understand that the use and disclosure of my PHI is for the purposes of my healthcare treatment and coordination.

- I have the right to revoke this authorization for release of my information at any time. The revocation must be made in writing to the PANG Collaborative, and it will NOT affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and have the right not to sign it. If I choose NOT to sign this authorization, I understand it may limit the services the PANG Collaborative can fulfill under my Client Agreement.
- I understand that any information disclosed pursuant to this authorization may not further be used or disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

_____ _____/_____/_____ _____

Signature Date Relationship to Client

_____

Printed Name of Signer if NOT the Client

Please note: Legal representatives must attach copies of authorization to act on the client's behalf as required by law. For example, healthcare power of attorney, legal guardianship, living will, birth certificate (children under 18 only) or healthcare surrogate.