

Authorization to Release Protected Health Information

I authorize Ironwood Physicians, PC:

Patient Name: To: From:	To: From: Name of Person or Facility: Address: Phone: Fax: Requested Information Physician's Notes Laboratory Re Biopsy Reports Prescriptions For Date(s) of Service:			Date of Bi	rth:								
Name of Person or Facility: Address: City: State: Zip:	Name of Person or Facility: Address: Phone: Requested Information Physician's Notes Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request												
Name of Person or Facility: Address: City: State: Zip:	Name of Person or Facility: Address: Phone: Requested Information Physician's Notes Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request												
Address: Fax: Email:	Address: Phone: Requested Information Physician's Notes Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request				To: From:								
Fax: Email: Requested Information Physician's Notes	Requested Information Physician's Notes Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request												
Requested Information Physician's Notes	Requested Information Physician's Notes Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request	City:		State:	Zip:								
Requested Information Physician's Notes	Requested Information Physician's Notes Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request			Email:									
Physician's Notes Laboratory Reports Radiology Reports Radiology Imaging Biopsy Reports Prescriptions Other (describe): For Date(s) of Service: Purpose of Request Personal Use Other (describe): Method of Delivery Fax Fax Fax #: Secure Email Mail Mailing Address: Office Location: Name of Person (if not Patient): Pick Up: Name of Person (if not Patient): Radiology Reports Radiology Reports Radiology Reports Radiology Reports Radiology Reports Radiology Imaging Radiology Imaging Radiology Imaging Radiology Imaging Radiology Reports Pater Secure S	☐ Physician's Notes ☐ Laboratory Re ☐ Biopsy Reports ☐ Prescriptions For Date(s) of Service: Purpose of Request	rux.		Linuii.									
Physician's Notes Laboratory Reports Radiology Reports Radiology Imaging Biopsy Reports Prescriptions Other (describe): For Date(s) of Service: Purpose of Request Personal Use Other (describe): Method of Delivery Fax Fax Fax #: Secure Email Mail Mailing Address: Office Location: Name of Person (if not Patient): Pick Up: Name of Person (if not Patient): Radiology Reports Radiology Reports Radiology Reports Radiology Reports Radiology Reports Radiology Imaging Radiology Imaging Radiology Imaging Radiology Imaging Radiology Reports Pater Secure S	☐ Physician's Notes ☐ Laboratory Re ☐ Biopsy Reports ☐ Prescriptions For Date(s) of Service: Purpose of Request												
Biopsy Reports	Biopsy Reports Prescriptions For Date(s) of Service: Purpose of Request				_								
For Date(s) of Service: Purpose of Request	For Date(s) of Service: Purpose of Request	atory Reports Radiology Re		ts	Radiology Im	aging							
Purpose of Request Personal Use	Purpose of Request		Other (describe):										
Personal Use Continued Patient Care Insurance Disability Legal Other (describe): Method of Delivery Fax Fax #: Secure Email Mailing Address: Mail Mailing Address: Office Location: Name of Person (if not Patient): Date: Name of Person (if not Patient):		For Date(s) of Service:											
Personal Use Continued Patient Care Insurance Disability Legal Other (describe): Method of Delivery Fax Fax #: Secure Email Mailing Address: Mail Mailing Address: Office Location: Name of Person (if not Patient): Date: Name of Person (if not Patient):													
Legal	Personal Use Continued Pa	Purpose of Request											
Method of Delivery Fax Fax #: Secure Email Email Address: Mail Mailing Address: Pick Up: Office Location: Date: Name of Person (if not Patient):		atient Care	ient Care Insurance		Disability								
Fax Fax #: Secure Email Email Address: Mail Mailing Address: Office Location: Date: Name of Person (if not Patient):	Legal Other (descri	ibe):											
Fax Fax #: Secure Email Email Address: Mail Mailing Address: Office Location: Date: Name of Person (if not Patient):	Mathad of Daliyary												
Secure Email Mail Mailing Address: Office Location: Name of Person (if not Patient):	For the												
Mail Mailing Address: Office Location: Name of Person (if not Patient): Date:	☐ Fax	Franil Address											
Office Location: Pick Up: Name of Person (if not Patient):	Secure Email Email Address:												
Pick Up: Name of Person (if not Patient):	Mail Mailing Address:												
Name of Person (if not Patient).		Office Location:			Date:								
	Pick Up: Name of Person (if not Patient):	Name of Person (if not Patient):											
Email Address for Portal Messages:	Email Address for Portal Message	25:											
Patient Portal		Patient Portal "Terms of Service" will be presented upon Sian In											

I UNDERSTAND THAT:

The information released may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases (STDs), behavioral or mental health, alcohol and/or drug use, and genetic testing information, if any records exist.

I may revoke this Authorization at any time: The revocation will not apply to information that has already been released in response to this Authorization; I must revoke this Authorization in writing.

I may refuse to sign this Authorization: My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure. A fee may be charged for providing the protected health information.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire one (1) year from the date of signing unless an earlier date is specified in writing.

specified in writing.								
I have read and understand the information in this Authorization form								
Signature of Patient:				Date:				
Printed Name:								
		OR						
An authorized representative of the patient must be identified on the Consent to Release Health Information Contact Form that we have on file, or be able to provide the appropriate legal documentation to support representative status.								
Signature of Authorized Represe	ntative:			Date:				
Printed Name:								
Relationship to Patient:								
For Office Use Only: Verification		I 🗆						
Prepared By: Verified By:	HIPAA Contact List Picture ID	☐ Legal Documentation ☐ Chart ID Photo	☐ Checked Fax Number/ Address ☐ HIPAA Contact List ☐ Legal Documentation					
vernieu by.		Chart in Filoto	I THE AA CONTACT LIST	Legal Documentation				