Provider 1ST

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Ph: 855-514-2378 | **Fax:** 800-818-2114 | **Email:** requests@provider1st.com | **Mail:** PO BOX 54650 Irvine CA 92619

Patient Name:	Date of Birth:
Patient's Address:	
Patient's Email:	Phone:

I authorize the following to disclose the above patient's protected health Information:

Facility/Physician Name:	
Address:	
Phone:	Fax:

Please disclose the above patient's protected health information to the following:

Person/Entity Name:	
Address:	
Email:	Fax:

Method of delivery:

☐ Fax ☐ Email ☐ Mail CD

There is some level of risk when releasing records via unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Purpose of Disclosure:

☐ Treatment/ Continuing Care ☐ Personal Use ☐ Insurance ☐ Disability ☐ Legal ☐ Other: _____

Date(s) of service to authorized to disclose:

Protected Health Information to be disclosed:

☐ Entire Record ☐ Other: _____ ☐ Billing Records

☐ History and Physical ☐ Imaging ☐ Progress Notes ☐ ER Report ☐ Consultation ☐ Operative Report

☐ Pathology Reports ☐ Cardiology ☐ Physician Orders ☐ Nurses Notes ☐ Lab Reports ☐ Radiology Reports

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment ☐ Sexually Transmitted Diseases

☐ Mental Health (excluding psychotherapy notes) ☐ Genetic Testing ☐ Reproductive Health Records

I understand that this authorization is effective for up to one year from the date of signature unless otherwise specified below. 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. I understand that records disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that the entity authorized to release my records will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization.

If applicable, specify other expiration date/event here: _____

_____ _____ _____ _____

Patient's Signature **Date** **Signature of Authorized Representative** **Date**

_____ _____

Printed Name of Patient/Authorized Representative **Relationship to the Patient**

Please submit the completed authorization to: Fax: 800-818-2114 OR Email: requests@provider1st.com