

## Protected Health Information Authorization for Release, Use, and Disclosure

Last Name	First Name		Date of Birth	MRN
Address		Phone	Email	
I authorize		to relea	se my Medical Records to:	☐ Me or ☐ Recipient:
Name of Authorized Person, Doctor, Hos		Phone		
Address			Fax	
ATTENTION PATIENT: I understand and authorize the release o If included in the medical record, this aut related information or testing), Mental H permitted by law.	horization includes the release o	f information protected by: Confid		
Information to be released:	Date(s) of Service	e:		
☐ Discharge Summary ☐ Emergency/Trauma Records ☐ Labs ☐ Abstract of Medical records = H&P, Dis ☐ Electronic Abstract = Discharge Summa		Results, Problem List, Medications	☐ Review F yTowerHealth) ☐ Speech A , Allergies and Procedure re	
□ Other =	☐ Complete Me	edical Record	i	
Reason for Disclosure:  Perso  Out of Tower Health Medical Group				
I would like to receive this information VI	A: □ Paper □ CD □ Secure E		Portal	
I understand the following: I may revoke to this authorization. The information die the terms of this authorization. I have th authorization and that my refusal to sign receive compensation for medical record or upon my death, whichever occurs early	sclosed in response to this author e right to inspect or copy the hea will not affect my ability to obtain copying in accordance with PA La	rization may be subject to re-disclo Ith information to be used or discl n treatment, or my eligibility for be	osure by recipient, and will osed as permitted by law. enefits (if applicable). Towe	no longer be protected under I may refuse to sign this er Health Medical Group may
Signature of Patient or Authorized Repr	esentative Date	Signature of Witness		Date
Printed Name of Patient		Printed Name of Witne	ss	
Relationship to Patient		 Title/Department		