Frontier
INFUSION CENTER

INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release, use or disclose information from the health record of:
Patient name_____ Date of birth _____
Address _____
Telephone No. _____ SSN _____
Covering the period (s) of health care from _____To_____
The following:

- Demographics/Insurance information
- Latest orders and progress notes
- X-ray reports
- Pathology
- Laboratory test
- Consultation Reports
- EKG
- Other _____

The information will be used or disclosed for the following purpose (s):

- To assist in the provision of services, care, and treatment of the individual.
- At the request of the individual.
- Other_____

From _____
Address_____
_____
Phone No _____
Fax _____

To _____
Address _____
_____
Phone No _____
Fax _____

You have a right to revoke this authorization by doing so in writing and mailing to the address above. Such revocation will be effective to the extent that action has been taken in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, only to the extent that other law provides the insurer with the right to contest a claim under the policy.
The information use or disclosed under the authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that protect individually identifiable health information from use or disclosure by health care providers.
I understand that I may inspect and /or copy the signed disclosure of protected health information form.

Date _____ Signature _____
Print name _____

_____
Authority of personal Representative if signing for the individual