SEMSA

Authorization for Release of Health Information ("Authorization")

NOTE: ALL Sections Must be Completed

Patient Name: _____
Printed (First) (MI) (Last Name)

Address: _____
Street Address City State Zip Code

Social Security Number:_____ Birth Date: _____ Telephone #: _____

I authorize SEMSA to release my health information, as specifically described below:

Release Information To: _____ Telephone #:_____
Full Name/Entity

Address: _____ Fax #: _____
Street Address City State Zip Code

Purpose of Request to Release:

☐ Treatment ☐ Personal/Patient Request ☐ Legal/Attorney ☐ Insurance

☐ Other (Specify): _____

For Date(s) of Service from: _____ to: _____ (Dates MUST be specified)

Information to be disclosed:

☐ Patient Care Report/Health Information ☐ Billing Records

I UNDERSTAND THAT:

- This Authorization will become effective immediately and will expire on _____ (Date). If no date is specified, this authorization will expire one (1) year from the signature date.
- I may revoke this Authorization at any time, in a written revocation sent to the Custodian of Records. However, I understand that my health information might have already been released.
- Information released by this Authorization might be re-disclosed by the recipient and might not be protected by state and federal privacy laws.

Signature of PATIENT ONLY: _____ Print Name: _____ Date: _____

Signature of Authority of Sign: _____ Print Name: _____
Proof of Authority MUST be attached (except for parents)

Address of Authority: _____ Telephone #: _____
Street Address City State Zip Code

Patient Rights: As a patient you have the right to access, copy or inspect your protected health information (PHI) in accordance with federal law. You also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices.