REED S. WILSON, M.D., F.A.C.C., F.A.C.P.

AUTHORIZATION FOR RELEASE OF (PHI) PROTECTED HEALTH INFORMATION

Medical Record Number:

Patient Name:

Birth Date:

SSN (Last Four Digits – Only):

I authorize _____ to release PHI to:
(name of person/ facility which has information)
Name of person/ facility to **receive** PHI:

Reed S. Wilson, M.D., Inc.
435 N. Roxbury Dr. #300
Beverly Hills, CA 90210

TYPE OF RECORDS

☐ MEDICAL	☐ MENTAL HEALTH (other than psychotherapy notes)

Cirlcle the Appropriate Records to Release

All Records		
History and Physicals	Admission and Discharge Notes	Progress Notes
Outside Physician Notes	Laboratory Results	Billing Statements
Cardiology Studies	Radiological and Diagnostic Studies	Psychological Evaluation
Drug and Alcohol Abuse Information	HIV/AIDs Test Results and Treatment	Other

SPECIFY DATE/ TIME PERIOD FOR INFORMATION SELECTED ABOVE:

THE PURPOSE OF THIS RELEASE IS (check one or more)

☐ At the request of the patient/patient representative

☐ Other (state reason) _____

Initials of Patient or Legal Representative: _____

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PROTECTED HEALTH INFORMATION

NOTICE

Reed S. Wilson, M.D., Inc. and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create PHI to provide to a third party.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires _____ (insert applicable date or event). If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE

_____ Date**:** _____ Time**:** _____AM / PM

(Signature of Patient / Legal Representative)

_____ _____

Printed Name Phone Number (Include Area Code)

_____

(If signed by someone other than the patient, indicate relationship to the patient)