## Authorization/Release for Protected Health Information (PHI) Records Furnished by CCI

Address Phone#  City State Zip Code  I hereby authorize the following facility to disclose Protected Health Information of the patient listed above Requested Delivery Method:   To:  Name/Title  Address  Address  Phone #  Phone #  Fax #  Reason to Release Protected Health  Information  Type of Access Requested:  Copies of Records  Inspection of the Pertinent info only Imaging/Radiology Physicians Orce Fecord  Expected:  City State Zip Code  Requested Health Information of the Pertinent info only Imaging/Radiology Physicians Orce Fecord  Requested Delivery Method:   Name/Title  Name/Title  Address  Address  Phone #  Fax #  Reason to Release Protected Health  Information  Type of Access Requested:  Copies of Records  Requested:  O Copies of Records  O Entire Record  O Lab  O Progress Notes  O Inspection of the Pertinent info only Imaging/Radiology  O Physicians Orce  O ER Records  O Cardiac Studies  O Billing Records	Patient Legal Name	Date of Birth	SS	SN !
Thereby authorize the following facility to disclose Protected Health Information of the patient listed above Requested Delivery Method:  \[ \triangle Mail \] \[ \triangle Fax \] \[ \triangle Pick up \] \[ \triangle To: \]  Name/Fitte \[ Name/Fitte \]  Address \[ Address \]  Phone # \[ Fax # \]  Reason to Release Protected Health Information  Type of Access Requested: Specific Date Range Requested:  O Copies of Records \[ \triangle \] Entire Record \[	Address	·	Phone#	
Requested Delivery Method: ☐ Mail ☐ Fax ☐ Pick up  To: Name/Title  Address  Address  Phone #  Fax #  Reason to Release Protected Health Information  Type of Access Requested:  Copies of Records  Inspection of the  Equation of the  Equation of He  Equation of History & Physical  Consult Report  Copies of Records  First Record  Equation of History & Physical  Consult Report  Equation of Physical  Equation of Physical	City	State	Zip Code	
To:   Name/Title   Name/Title   Address   Address   Address   Address		facility to disclose Protected Reque	. d Health Information of the patien sted Delivery Method: [] Mail []	nt listed above
Address			To:	-
Reason to Release Protected Health Information  Type of Access Requested:  Copies of Records Inspection of the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Imaging/Radiology of Physicians Order (and the pertinent info only of Patient/Parent/LegalGuardian	Address			
Reason to Release Protected Health Information  Type of Access Requested:  O Copies of Records O Inspection of the gecord O Entire Record O Inspection of the gecord O Inspection O Inspectio	Phone #		Phone #	
Reason to Release Protected Health Information  Type of Access Requested:  Copies of Records Inspection of the record on the record of the protected record of the record of				
Type of Access Requested:    O   Copies of Records   O   Entire Record   O   Lab   O   Progress Notes				
o Inspection of the cord of th		•		
cknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, whiatric, HIV results or AIDS information.  Inderstand that this authorization may be revoked by me at any time except to the extent that action has been taken eliance upon it.  Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and onger protected.  Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and onger protected.  Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and onger protected.  Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and onger protected.  Information used or disclosure of the fulfillment of this request. See fee schedule below.  Information mean that only records erated by this facility will be released.  Information mean that only records erated by this facility will be released.  Information mean that only records erated by this facility will always be a fee for copying of records.  Information may be extent that action has been taken extent that action has been taken extent that action has been taken extent that the extent that action has been taken extent that action has been taken extent that the extent that action has been taken extent that the extent that action has been taken extent that the extent that action has been taken extent that the extent that action has been taken extent that the extent that action has been taken extent that action has been taken extent that the extent that action has been taken extent th	o Inspection of the record	o Pertinent info only o ER Records o History & Physical o Consult Report o Operative Report o Rehabilitation	o Imaging/Radiology o Cardiac Studies o Demographics o Nursing Notes	o Physicians Ordo o Billing Records o Immunizations
Achieved that this authorization may be revoked by me at any time except to the extent that action has been taken eliance upon it. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and longer protected. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and longer protected. Information used or disclosed with the fulfillment of this request. See fee schedule below. Information that there may be a fee involved with the fulfillment of this request. See fee schedule below. Information that the term Complete Chart for release of Protected Health Information mean that only records the erated by this facility will be released. In the protected health information. In the closed clinics there will always be a fee for copying of records.  In the content of the extent that action has been taken eliance upon it.	xpiration: This authorization shall	<ul> <li>Fulfillment of this</li> </ul>		
longer protected.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that the term Complete Chart for release of Protected Health Information mean that only records erated by this facility will be released.  Inderstand that the term Complete Chart for release of Protected Health Information mean that only records erated by this facility will be released.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that there may be a fee involved with the fulfillment of this request. See fee schedule below.  Inderstand that the term Complete Chart for release of Protected Health Information mean that only records with the fulfillment of this request.  Inderstand that the term Complete Chart for release of Protected Health Information mean that only records with the fulfillment of this request.  Inderstand that the term Complete Chart for release of Protected Health Information mean that only records with the fulfillment of this request.  Inderstand that the term Complete Chart for release of Protected Health Information mean that only records with	ychiatric, HIV results or AIDS info nderstand that this authorization m reliance upon it.	ormation. ay be revoked by me at any	time except to the extent that ac	tion has been taken
ature of Patient/Parent/LegalGuardianDate	longer protected.  Addrestand that there may be a fee in  Addrestand that the term Complete C  Be erated by this facility will be rele  The read the above and authorize the	volved with the fulfillment hart for release of Protecte ased. e disclosure of the protecte	t of this request. See fee schedul d Health Information mean that o d health information.	le below.
Fee Schedule	•			
		Fee Schedule		

be charged.

\* To ensure timely processing of medical records, please fill authorization out completely.

a copy of his/her patient record, not to exceed \$14.00 for the first ten or fewer pages, \$.50 per page for pages 11-40, and \$.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any may