REITER, HILL, & JOHNSON

FORM 002: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) TO REITER, HILL, & JOHNSON

Section A: This section must be completed for ALL Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**
Name and Address of Referring Practice:	**Release to:** Reiter, Hill, & Johnson ATTN: HIPAA Privacy Officer 1133 21st Street NW, Suite 200 Washington, DC 20036-3324 Phone: (202) 331-1740 Fax: (202) 296-9784	

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: **Event:**

Purpose of Disclosure:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

This request is NOT for psychotherapy notes. If it were, a separate authorization would be required for other items below. **Reiter, Hill, & Johnson** may check as many items below as needed.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐All PHI in Medical Record ☐Registration Sheet ☐Medical History Form ☐Medication Sheet ☐Office Visit Notes ☐Nurse Notes		☐X-Ray Films ☐Lab/Test Results ☐Operative Reports ☐Pathology Reports ☐Other Hospital Information ☐Physical Therapy Notes		☐Notes from Other Providers ☐Disability/FMLA Forms ☐Work/School Notes ☐Itemized Bill ☐Other: ☐Other:	

I understand that:

1. **Reiter, Hill, & Johnson** will not condition treatment on my providing this authorization, except in the case of my participation in research related treatment.
2. I may refuse to sign this authorization and that it is strictly voluntary.
3. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, by requesting it in writing. Under **District of Columbia** law this information will be provided to me within 15 days of my request.
4. I may revoke this authorization at any time by notifying **Reiter, Hill, & Johnson's** Privacy Officer, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation.
5. If the requester or receiver is not a health plan, health care clearing house, or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
6. I acknowledge that I have the right to a copy of this authorization after I have signed it.

Section B: This Request for the PHI is NOT for the purpose of marketing.

Reiter, Hill, & Johnson will ☐ will not ☐ receive financial or in-kind compensation in exchange for using or disclosing this information.

Section C: Signatures

I have read the above and authorize the disclosure of my Protected Health Information as described on this form.

Signature of Patient or Patient's Representative	**Date:**

Relationship of Patient's Representative, if applicable:

The authority of the patient's representative (attach evidence of authority to this Authorization):