

# 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 5550 Friendship Blvd, Suite 210 Chevy Chase, MD 20815  Phone: (301) 654-5700 Fax: (301)718-8330		
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. <b>Reiter, Hill, &amp; Johnson</b> may check as many items below as needed.					
Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Registration Sheet <input type="checkbox"/> Medical History Form <input type="checkbox"/> Medication Sheet <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Nurse Notes		<input type="checkbox"/> X-Ray Films <input type="checkbox"/> Lab/Test Results <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Other Hospital Information <input type="checkbox"/> Physical Therapy Notes		<input type="checkbox"/> Notes from Other Providers <input type="checkbox"/> Disability/FMLA Forms <input type="checkbox"/> Work/School Notes <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I understand that:					
<ol style="list-style-type: none"> <li>1. <b>Reiter, Hill, &amp; Johnson</b> will not condition treatment on my providing this authorization, except in the case of my participation in research related treatment.</li> <li>2. I may refuse to sign this authorization and that it is strictly voluntary.</li> <li>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 <b>Maryland</b> law this information will be provided to me within 15 days of my request.</li> <li>4. I may revoke this authorization at any time by notifying <b>Reiter, Hill, &amp; Johnson's</b> Privacy Officer, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation.</li> <li>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.</li> <li>6. I acknowledge that I have the right to a copy of this authorization after I have signed it.</li> </ol>					
Section B: This Request for the PHI is NOT for the purpose of marketing.					
<b>Reiter, Hill, &amp; Johnson</b> will <input type="checkbox"/> will not <input type="checkbox"/> 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 <u>evidence</u> of authority to this Authorization):					