REITER, HILL & JOHNSON OF ADVANTIA

# FORM 001: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FROM REITER, HILL & JOHNSON OF ADVANTIA

## Section A: This section must be completed for ALL Authorizations

| **Patient Name:** | **Birth Date:** | **Social Security No. *(optional)*:** |
|---|---|---|
| **Provider's Name and Address:**<br>Reiter, Hill & Johnson of Advantia<br>ATTN: HIPAA Privacy Officer<br>1133 21st Street NW, Suite 200<br>Washington, DC 20036-3324<br>Phone: (202) 331-1740 Fax: (202) 223-1017<br>Email: medicalrecords@rhjn-obgyn.com | **Practice Representative:**<br>**Address:**<br>**Phone:** | |

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

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

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

I understand that:

1. **Reiter, Hill & Johnson of Advantia** 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 of Advantia**'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 mayno 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: Is the Request of the PHI for the purpose of marketing? Yes ☐ No ☐

If yes, the health care provider must complete Section B, otherwise skip to Section C.

**Reiter, Hill & Johnson of Advantia** 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):**