Lisa S. Ball, FNP PLLC
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Outgoing

_____ Date of Birth:_____
Patient Name

_____ Daytime Phone:_____
Address

_____ _____
City, State, Zip Social Security Number

I authorize release of my protected health information (PHI)
TO:
Name: _____

Address: _____

_____

This authorization does not expire, unless otherwise stated.

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.

I want the following information to be disclosed (Please specify):
_____
_____
_____

The purpose of this disclosure is (Please specify):
_____
_____

Please be aware that information disclosed pursuant to this authorization is subject to redisclosure by the recipient and is no longer protected by this organization.

_____
Signature of Patient or Representative

_____
If representative, Relationship to Patient

Date: _____

To Be Completed by Lisa S. Ball, FNP Personnel Only:
Patient Account Number: _____
Date Sent: _____
Sender (Please Print): _____
Signature of Sender: _____

PATIENT TO RECEIVE COPY OF THIS FORM

All fields must be completed for Release of Protected Health Information
Lisa S. Ball FNP will not condition the provision of treatment on the provision of this authorization