Mona Venzon Rice, MD
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RETURN THIS PAGE TO OFFICE STAFF OR DOCTOR

Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Patient Address:_____
Street/P.O. Box City State Zip Code

I authorize Mona Venzon Rice, MD

□ To release PHI to: □ To obtain PHI from: □ To exchange PHI with

For the purpose of (Check):
□ Coordination & continuity of care □ Legal matter
□ Personal use □ Other purpose (specify) _____
I authorize the following PHI to be disclosed (Check):
□ In-person, telephone, and/or electronic communication □ Complete record
□ Intake/discharge □ Progress notes
□ Other PHI (specify) _____

INITIAL:
____This authorization may be relied upon when transmitted by fax. I further authorize the PHI to be sent by fax. I agree to hold Mona Venzon Rice, MD harmless if any PHI transmitted by fax does not reach the authorized recipient.

____I understand that this authorization will expire on the following date, event or condition: _____
I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

___ I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

___ I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

___I further understand that I may request a copy of this signed authorization.

_____ _____
Signature of Patient (if 18 & above) / Parent or Legal Guardian (if 17 & below or has a legal guardian) Date