MOZAIC
MoZaic Care

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: …….. Date of Birth: ……

I hereby authorize: ……
Name of Person/Organization Disclosing PHI

Phone: …….. Fax: …….. Address: ……

to release the following information to: ……
Name of Person/Organization Receiving PHI

Phone: …….. Fax: …….. Address: ……

Information to be shared:

Dates of service for records requested:
Beginning: ……
Thru: ……

- ☐ ALL RECORDS
- ☐ Clinical Notes
- ☐ Lab/Pathology Reports
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify)……

Purpose of Release

- ☐ Copy for own use
- ☐ Transfer of Care
- ☐ Legal/Insurance

Copy Fees:
$25.00 – over 10 pages
$40.00 - Legal/Insurance
Please allow 7-10 business days for receipt of records

Sensitive Records require specific patient authorization. Please check the applicable box below to request the following:

- ☐ HIV/STDs
- ☐ Genetic Testing
- ☐ Mental Health

Authorization for General Release of Information

I understand that:

- By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed above. I understand I can revoke this authorization at any time, except to the extent that action has ben taken in reliance upon it. Revocation must be made in writing.

Signature of Patient or Legal Representative

…….. ……..
Signature of Patient/Legal Representative Date

……..
If signed by legal representative, please specify relationship to patient