Instruction for completion of "Authorization To Use and/or Disclose Protected Health Information:

Third party requesters - If you are requesting a Legacy Health patient's information to be released directly to you, you will need to assure that you have our patient or their authorized healthcare representative complete the Authorization to Use and/or Disclose Protected Health Information form. Additionally, you must provide any supporting documentation for the authorized healthcare representative **and** your own cover letter.

Pertinent information for completing a HIPAA Compliant authorization:

1. Patients Full Name

2. Patients Date of Birth

3. Healthcare Provider to **Release** Information

4. Person or Agency to **Receive** Information

5. Purpose of release

6. Identify the date(s) of service of the healthcare information you would like released

7. Patient can initial for sensitive information - *(must be initialed, not checked)* in the space next to each type of medical record/information that the patient wishes to disclose to the person or agency receiving medical records.

8. You may add an expiration date for the future. If this is left blank the authorization will expire 1 year after the date of signing the form

9. Patient signature

     a. or Patient's Legal Healthcare Representative signature*

10. Date signed

11. Printed name or person signing the form

12. Relationship to patient

Additional information that is not required, but is helpful if we have questions:

1. The patient's or personal representatives phone number

2. List of other names used by the patient

3. The patient should retain a copy of the authorization they have signed.

*If a healthcare representative is signing for the patient, please attach a copy of the legal documentation that supports their rights to sign on behalf of the patient.

Please Note: Third party requests are charged at the State allowable third party rate.

Thank you,
Legacy Health
Health Information Management – Release of Information Department