ADD PRACTICE LOGO HERE

PURPLE TEXT IS FOR PRACTICE SETUP. Replace every purple placeholder, review each purple instruction, and delete setup-only text before exporting the final PDF and uploading it to Allia.

Authorization to Obtain or Disclose Protected Health Information

Fillable PDF | Practice-branded template for patient use.

Template notice: This sample is a starting point, not legal advice. The practice should adapt it to its services, payer contracts, state law, licensing requirements, and current federal requirements, and obtain appropriate legal or compliance review before use. Delete this notice from the patient-facing version.

Practice information

Practice name: [PRACTICE NAME]

Legal entity: [LEGAL ENTITY]

Practice address: [PRACTICE ADDRESS]

Practice phone: [PRACTICE PHONE]

Practice fax or secure-transfer method: [PRACTICE SECURE TRANSFER]

Patient information

Patient legal name *

Previous or other name used, if relevant

Date of birth *

Address *

Phone

Email

Direction of exchange

- ☐ Obtain information from the person or organization below
- ☐ Disclose information to the person or organization below
- ☐ Exchange information in both directions

Person or organization

Name *

Organization or relationship to patient *

Address

Phone

Fax

Email or secure-transfer address

Information authorized

- [ ] Entire designated record set
- [ ] Psychiatric evaluation
- [ ] Progress notes
- [ ] Treatment plans
- [ ] Medication list and medication-management notes
- [ ] Laboratory or diagnostic results
- [ ] Consultation reports
- [ ] Psychological or neuropsychological testing
- [ ] Billing and payment records
- [ ] Discharge or transfer summary

Other specific information

Records from date

Records through date

Sensitive information

Select a category only if the authorization should include it and applicable law permits it to be included in this form.

- [ ] HIV-related information
- [ ] Sexually transmitted infection information
- [ ] Genetic information

- [ ] Substance-use-disorder records protected by 42 CFR Part 2
- [ ] Other specially protected information

Psychotherapy notes and substance-use-disorder counseling notes may require a separate, specific authorization and should not be included merely by selecting the entire record.

Purpose

- [ ] Ongoing treatment or care coordination
- [ ] Referral or transfer of care
- [ ] Insurance, payment, or benefits
- [ ] Legal or administrative matter
- [ ] At my request

Other specific purpose

If Part 2 records will be used or disclosed in a civil, criminal, administrative, or legislative investigation or proceeding against the patient, use a separate authorization reviewed for that purpose.

Expiration

Expiration date or expiration event related to the patient or purpose *

A more restrictive state law may require a shorter authorization period.

Your rights and important information

- Signing this authorization is voluntary.
- Treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing, except when permitted by law.
- You may revoke this authorization in writing at any time. Revocation will not affect information already used or disclosed in reliance on it.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA unless another law continues to protect it.
- You have a right to receive a copy of the signed authorization.
- A copy or electronic version may be treated as valid to the extent permitted by law.

Contact or method for written revocation: [REVOCATION CONTACT]

Limits or special instructions

Authorization

☐ I have read and understood this authorization and authorize the use or disclosure described above. *

Printed name of signer *

Relationship to patient and authority to act, if applicable

Practice processing

Complete this section during processing, or delete it before upload if the practice records these details elsewhere.

Processed by: [PROCESSED BY]

Date processed: [DATE PROCESSED]

Secure transmission method: [TRANSMISSION METHOD]

Disclosure or receipt completion status: [COMPLETION STATUS]

Copy provided to patient: [YES / NO]