

**Reiter, Hill, Johnson & Nevin**  
**FORM 001: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FROM REITER, HILL, JOHNSON & NEVIN**

Section A: This section must be completed for ALL Authorizations					
<b>Patient Name:</b>		<b>Birth Date:</b>		<b>Social Security No. (optional):</b>	
<b>Provider's Name and Address:</b> <b>Reiter, Hill, Johnson &amp; Nevin</b> <b>1145 19th Street. NW, Suite 410</b> <b>Washington, DC 20036-3716</b> Phone: (202) 331-1740 Fax: (202) 296-9784 Email: medicalrecords@rhjn-obgyn.com		<b>Recipient's Name:</b>			
		<b>Address 1:</b>			
		<b>Address 2:</b>			
		<b>City:</b>		<b>State:</b>	<b>Zip:</b>
		<b>Fax:</b>	<b>Phone:</b>		
This authorization will expire on the following: (Fill in the Date or the Event, but not both.)					
<b>Date:</b>			<b>Event:</b>		
<b>Purpose of Disclosure:</b>					
<b>DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED</b>					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
<b>Description:</b>	<b>Date(s)</b>	<b>Description:</b>	<b>Date(s)</b>	<b>Description:</b>	<b>Date(s)</b>
<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Registration Sheet <input type="checkbox"/> Medical History Form <input type="checkbox"/> Medication Sheet <input type="checkbox"/> Office Visit Notes <input type="checkbox"/> Nurse Notes		<input type="checkbox"/> Ultrasound Reports <input type="checkbox"/> Lab/Test Results <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Other Hospital Information <input type="checkbox"/> Physical Therapy Notes		<input type="checkbox"/> Notes from Other Providers <input type="checkbox"/> Disability/FMLA Forms <input type="checkbox"/> Work/School Notes <input type="checkbox"/> Itemized Bill <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I understand that:					
1. <b>Reiter, Hill, Johnson &amp; Nevin</b> will not condition treatment on my providing this authorization, except in the case of my participation in research related treatment. 2. I may refuse to sign this authorization and that it is strictly voluntary. 3. I may see and obtain a copy of the information described on this form, for a reasonable copy fee, by requesting it in writing. Under <b>District of Columbia</b> law this information will be provided to me within 15 days of my request. 4. I may revoke this authorization at any time by notifying <b>Reiter, Hill, Johnson &amp; Nevin's</b> Privacy Officer, in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation. 5. If the requester or receiver is not a health plan, health care clearing house, or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 6. I acknowledge that I have the right to a copy of this authorization after I have signed it.					
<b>Section B: Is the Request of the PHI for the purpose of marketing? Yes <input type="checkbox"/> No <input type="checkbox"/></b>					
If yes, the health care provider must complete Section B, otherwise skip to Section C.					
<b>Reiter, Hill, Johnson &amp; Nevin</b> will <input type="checkbox"/> will not <input type="checkbox"/> receive financial or in-kind compensation in exchange for using or disclosing this information.					
<b>Section C: Signatures</b>					
I have read the above and authorize Reiter, Hill, Johnson & Nevin to disclose the Protected Health Information as described on this form.					
<b>Signature of Patient or Patient's Representative</b>				<b>Date:</b>	
<b>Relationship of Patient's Representative, if applicable:</b>					
<b>The authority of the patient's representative (attach <u>evidence</u> of authority to this Authorization):</b>					