

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					
Patient Name:		Birth Date:		Social Security No. (optional):	
Provider's Name and Address: Reiter, Hill, Johnson & Nevin 407 N. Washington, St., Suite 105 Falls Church, VA 22046 Phone: (703) 533-9211 Fax: (703) 533-9401 Email: medicalrecords@rhjn-obgyn.com		Recipient's Name:			
		Address 1:			
		Address 2:			
		City:		State:	Zip:
		Fax:			
This authorization will expire on the following: (Fill in the Date or the Event, but not both.)					
Date:			Event:		
Purpose of Disclosure:					
DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED					
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.					
Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<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. Reiter, Hill, Johnson & Nevin 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 District of Columbia 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 Reiter, Hill, Johnson & Nevin's 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.					
Section B: Is the Request of the PHI for the purpose of marketing? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If yes, the health care provider must complete Section B, otherwise skip to Section C.					
Reiter, Hill, Johnson & Nevin will <input type="checkbox"/> will not <input type="checkbox"/> receive financial or in-kind compensation in exchange for using or disclosing this information.					
Section C: Signatures					
I have read the above and authorize Reiter, Hill, Johnson & Nevin to disclose the Protected Health Information as described on this form.					
Signature of Patient or Patient's Representative				Date:	
Relationship of Patient's Representative, if applicable:					
The authority of the patient's representative (attach <u>evidence</u> of authority to this Authorization):					