The Office of Dr. Sherri L. Graf, D.O. and Dr. Ebonie Z. Harris, M.D.
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Authorization Form

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual can also request that confidential communication, whether telephone communication or correspondence, be directed to an alternate site such as the individual's office. Please fill out your personal information and any of the sections that apply to you below.

Personal Information:

_____
Patient Name

_____
Address

_____ _____ _____
Phone Date of Birth Social Security Number

This will allow us to obtain your medical records from your current or previous physician or you can provide authorization for your current or previous physician to obtain medical records from our practice:

Records are requested FROM:

_____
Name

_____
Phone/Fax

_____
Address

To be disclosed TO:

_____
Name

_____
Phone/Fax

_____
Address

The type and amount of information to be disclosed is as follows:

☐ My health information relating to the following treatment or condition:_____
☐ Most recent 3 years of record
☐ My health information for the date(s): _____
☐ Entire medical record
    ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
    ☐ Include ☐ Exclude: My health information related to HIV/AIDS
    ☐ Include ☐ Exclude: My health information related to psychological or psychiatric conditions
☐ Other: _____

Purpose of disclosing this health information: _____

I authorize the disclosure of health information of the individual(s) named above:

_____ _____
Patient Signature Date

This section is to let our practice know how you would like to receive your Personal Health Information:

I wish to be contacted in the following manner *(check all that apply):*

( )Home Telephone_____
__Leave message with detailed information
__Leave message with call back number only

( )Work Telephone_____
__Leave message with detailed information
__Leave message with call back number only

( )Cell Number_____
__Leave message with detailed information
__Leave message with call back number only

( )Written Communication:
Home Address -
Alternate Address -
__Mail to my home address
__Mail to my alternate address

I hereby consent to the release of my Protected Health Information (PHI) to the following individual(s). I understand this authorization will be in effect until the time it is revoked.

1)_____ Expiration: _____

2)_____ Expiration: _____

3)_____ Expiration: _____

_____ _____ _____

Patient Signature Print Name Date