Nassim and Associates, PSC
2305 Green Valley Road
New Albany, IN 47150
Phone 812.949.0405
Fax 812.949.0445

AUTHORIZATION FOR RELEASE OF PHI, PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:
PHYSICIAN NAME:_____
ADDRESS:_____
_____
PHONE NUMBER:_____
to disclose pertinent PHI including medical information, test results, x-rays, correspondence and surgical records about the child/children listed below to Nassim & Associates, PSC.

The PHI to be released (please specify):
□ Entire medical record (INCLUDING psychiatric, mental health, alcohol and/or drug abuse and sexually transmitted disease information)
□ Entire medical record (EXCLUDING psychiatric, mental health, alcohol and/or drug abuse and sexually transmitted disease information)
□ Specific portions: (Please list specific portions such as, service, level of detail, origin of information, dates etc.)
_____

Reason or need for release of records (please specify):
☐Personal use
☐Transfer of care
☐Other (please specify)_____

Patient Name(s):
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

I understand that I may revoke this authorization by submitting a revocation in writing to the Privacy Officer at Nassim & Associates, PSC at the above named address except to the extent that Nassim & Associates, PSC has acted in reliance upon this authorization.

This authorization expires 60 days from receipt unless otherwise indicated.

Signature of Parent/Guardian:_____

Printed Name: _____Relationship to Patient:_____

Address: _____

Date: _____ Time: _____

For office use only

Acct #:_____Witnessed by:_____Date:_____