Lisa S. Ball, FNP PLLC
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Incoming

_____ Date of Birth:_____
Patient Name

_____ Daytime Phone:_____
Address

_____ _____
City, State, Zip Social Security Number

I authorize release of my protected health information (PHI)

FROM:
Name: _____
Address: _____
_____

TO:
Lisa S. Ball, FNP PLLC
1140 Youngs Road
Williamsville, NY 14221

This authorization does not expire, unless otherwise stated.

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.

I want the following information to be disclosed (Please specify):

_____
_____
_____

The purpose of this disclosure is (Please specify):

_____
_____

Please be aware that information disclosed pursuant to this authorization is subject to redisclosure by the recipient and is no longer protected by this organization.

_____
Signature of Patient or Representative

_____
If representative, Relationship to Patient

Date: _____

PATIENT TO RECEIVE COPY OF THIS FORM

To Be Completed by Lisa S. Ball, FNP Personnel Only:
Patient Account Number: _____
Date Sent: _____
Sender (Please Print): _____
Signature of Sender: _____

All fields must be completed for Release of Protected Health Information

Lisa S. Ball FNP will not condition the provision of treatment on the provision of this authorization