ALLIED INFOTECH CORPORATION
DOCUMENT STORAGE AND MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No. :**
Patient Phone Number:	**Patient Email Address:**	
Provider's Name:	**Recipient's Name:**	
Provider's Address: c/o Allied Infotech Corporation 2170 Romig Rd., Akron OH 44320 (P) (330)753-8383 (F) (330) 753-5017	**Address:** **City:** **State:**	**Zip:** **Phone Number:**

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

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in medical record ☐ Discharge Summary ☐ History & Physical ☐ Ambulance Run Sheet ☐ Consult ☐ X-Ray Report ☐ Lab/Pathology Report		☐ Operative Report ☐ Cardiac Cath Report ☐ Physical Therapy ☐ EKG/Rhythm Strips ☐ Nursing Information ☐ Discharge/Transfer Form ☐ ER Information		☐ Labor/delivery sum. ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-92: ☐ Other: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ________________ (Initial) If not applicable, check here. ☐

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Identifying Information

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Representative:	**Date:**
Print Name of Patient or Representative:	**Relationship to Patient:**
☐ **Copy of Identification Attached** **Type_______________________________** **Number____________________________**	**(Driver's License, DMV Identification, Birth Certificate, Benefits Identification Card, Managed Care Card, State or Federal Employee ID Card)**

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.

Notarized by____________________________________ **On_______________________ (Date) Notary Public Number ________________________**	**NOT OFFICIAL UNLESS STAMPED BY NOTARY PUBLIC**

Section D. Payment Information

Allied Infotech Corporation will be distributing a complete copy of the entire paper medical record via UPS, please mail your completed request and payment for $19.00 to:

ALLIED INFOTECH CORPORATION
RELEASE OF INFORMATION
2170 ROMIG ROAD
AKRON, OHIO 44320

Please make checks or money order payable to **ALLIED INFOTECH CORPORATION**

Note: The $19.00 fee is non-refundable and covers search and retrieval of files.

Digital Imaging of patient chart: All patient charts are converted to digital image. All images are in black and white. All images are provided to patient or provider on compact disk (CD)

Duplication Fees:
$0.60/page (pages 1-75)
$0.50/page (pages 76-100)
$0.25/page (pages 100+)

Additional charges for the cost of shipping and handling will be invoiced to the patient once those charges have been calculated. **Payment of these services must be made prior to the release of records.**