# HIPAA Authorization to Release Protected Health Information (PHI)

**I, _____, *(Patient Name),* hereby authorize Summit Medical Consultants, PLLC to release the following Protected Health Information (PHI) to the following individual(s) for the stated purpose:**

Name of Recipient(s):

_____

_____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____
*(PHI authorized to be sent via fax)*

Relationship to Patient: _____

Information Authorized to be Released:

_____

_____

_____

Purpose(s) of the Release Authorized:

_____

_____

_____

This authorization shall expire one (1) year from the date of its execution, unless earlier revoked by me or my personal representative. I understand I may revoke this authorization by providing written notice of such revocation to Summit Medical Consultants, PLLC at any time. I understand that Summit Medical Consultants, PLLC will not condition my treatment, payment, or enrollment/eligibility for benefits on whether I sign this authorization or not. I understand that it is possible that information disclosed pursuant to this authorization may be subject to redisclose by individuals who see it, and such individuals may not be bound by HIPAA. I understand that I will receive a copy of this authorization for my personal records.

_____ _____
Print Name Telephone

_____ _____
Signature Date