

Patient Account Number _____
State Where Service was Rendered _____

PST Services, Inc.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or entity authorized to receive the information is not a healthcare provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Social Security No.: _____ Date of Birth: _____

Person/entity authorized to receive the information: _____

Mailing Address: _____

Specific description of information (including dates): _____

The purpose of the use or disclosure is: _____

Will the person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

Yes _____ No _____

• I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

• I understand that this authorization will expire on _____ or 1 year from signature date or period as specified by state law, whichever date occurs first.

• I understand that I may revoke this authorization at any time by notifying PST Services Inc. in writing. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by PST Services Inc. before PST Services Inc. received the revocation. I also understand that more information regarding revocation of this authorization may be covered in PST Services Inc.'s Notice of Privacy Practices.

Initials _____

Signature of Patient or
Patient's Legal Representative

Date

Printed Name

Relationship of Legal Representative to
Patient