ICPA Authorization for Release of Information

This Authorization is optional. It is used only if you want us to release information to a third party not already covered under the **ICPA Notice of Privacy Practices**, for example your life insurance company, employer, school or community organization.

Patient Name:		Date of Birth:	

I authorize the Infusion Center of Pennsylvania, LLC to release information about me to the following third party, subject to any limitations specified. I understand that this ICPA Authorization for Release of Personal Information may include Protected Health Information (PHI), unless I specifically restrict it.

I understand that this information will not be released automatically. It must be requested by each party.

Name:		Telephone Number:	
☐ Release any information requested by the party named above.			
☐ Release any information except: ☐ Release only the following information:			
☐ Release the information by phone *anytime you receive a call.*			
☐ Fax the information to:			
☐ Mail the information to:			

x _____ _____

Signature Date Signed

_____ _____

Print Name Relationship to Patient