Authorization for Release of 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 organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____

Date of Birth: _____ **Phone Number:** _____

I HEREBY AUTHORIZE:

_____
_____
_____

TO RELEASE INFORMATION TO:

_____
_____
_____

HEALTH INFORMATION TO BE RELEASED:

- ❑ Medical Records from _____to_____
- ❑ Procedure Reports
- ❑ Lab Reports
- ❑ Billing Records – Specify
- ❑ X-Ray Reports
- ❑ Other _____
- ❑ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, consultations, and records sent to you by other health care providers.

PURPOSE OR NEED FOR DISCLOSURE:

- ❑ Further medical care
- ❑ At the request of patient
- ❑ Other _____

My medical records may include information, which may be specially protected. I authorize the release of any information regarding:

HIV _____ Drug and Alcohol treatment. _____

EXPIRATION:

This authorization will expire on ___/___/____. If I do not indicate a date, this will expire 1 year from the date of my signature below.

I may revoke this authorization at any time, in writing, before the information has been released. I further understand that I have a right to receive a copy of this authorization upon request.

_____ _____

Signature of patient or patient's representative **Date**

(This form MUST be completed before signing)

Printed name of person signing form: _____

Relationship to the patient: _____