

AUTHORIZATION FOR RELEASE OF INFORMATION



Patient Name _____

Address: _____ City _____ State _____ Zip code _____

Phone: _____ Disclosure Reason: _____

Name of Recipient: _____ Phone: _____ Fax: _____

Address: _____ City _____ State _____ Zip code _____

Date(s) of Treatments Being Disclosed: From: _____ To: _____

I hereby authorize the use or disclosure of my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected by federal regulations.

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Medical Records # (if Known): _____

Name of Facility and/or Person That is Releasing My Records: _____

Person(s) Receiving My Health Information: _____

Description of Information Being Disclosed: _____

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Abstract/ Pertinent Information | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Emergency Department Record | <input type="checkbox"/> HIV/ AIDS Information | <input type="checkbox"/> Drug/ Alcohol Treatment Information | |
| <input type="checkbox"/> Other: _____ | | | |

Purpose of Disclosure: _____

Example: " At the Request of the Patient."

Expiration: If the health information to be disclosed contains HIV/AIDS or drug and alcohol abuse treatment records, this authorization will expire in 60 days. Otherwise, select either of the following expiration events:

- 1 year from the date in which I or my legal representative sign this authorization.
- Upon happening of the following events: _____

Right to revoke: I understand that I may revoke this authorization at any time by providing written notice to the Director of Medical Records at the address of the facility in which I received my medical care. I understand that my revocation won't have any effect on any action taken by this organization before they receive the revocation and is not effective if the authorization was obtained as a condition of obtaining insurance coverage. The insurer has the legal right to contest a claim under my insurance policy.

I understand that the organization will not condition my treatment, payments, enrollment in a health plan, or eligibility for benefits on my signing this authorization. I understand that i have the right to inspect or copy the health information to be used or disclosed pursuant to this authorization.

TO BE COMPLETED BY THE ORGANIZATION IF THIS AUTHORIZATION IS FOR MARKETING: The organization will receive financial or in-kind compensation in exchange for using or disclosing the health information described above: YES NO

Patient Signature _____ Date: _____

If signed by the patient's legal representative:
Printed name of representative: _____ Relationship to the patient _____