



Authorization to Disclose Protected Health Information

Authorization may be invalid if form not completely filled out

Patient Information:			
Patient Name		DOB	
Address		Phone Number	
City	State	Zip Code	
Release Records From:			
Provider/Organization			
Address		City	
State	Zip Code	Phone Number	Fax Number
Release Records To:			
Provider/Organization			
Address		City	
State	Zip Code	Phone Number	Fax Number

Purpose for disclosure:

Continuation of Care Insurance Legal Personal Other: _____

Treatment Date(s):

Treatment dates from _____ to _____ Specific date: _____ ALL treatment dates

Information to be released:

<input type="checkbox"/> Complete Health Record	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultations	<input type="checkbox"/> Other (<i>please specify</i>)
<input type="checkbox"/> Clinic notes	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Immunization Records	
<input type="checkbox"/> Hospital Notes	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Patient Billing records	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Photographs	

I, the undersigned, request and authorize release of health information as indicated/described above. I understand that:

- The requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes. Release of Psychotherapy Notes requires a separate authorization.
- This authorization will expire one-year from the date signed below unless specified (_____) or revoked in writing by myself (or authorized representative). Any revocation will not apply to information that has already been released in response to this authorization.
- I may refuse to sign this authorization. Refusal will not affect my treatment, payment, enrollment, or eligibility for benefits.
- After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient (or Authorized Representative)	
Printed Name	Date
<i>If Authorized Representative, please explain authority to act on the behalf of the Patient and documentary evidence of appropriate papers shall be required to accompany this authorization</i>	