Authorization for Release of Information

PATIENT NAME:_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act 45 C.F.R. Parts 160 and 164)

I hereby authorize _____ Provider Phone #_____
(Print Name of Provider)
to release information from my medical record as indicated below to:

NAME: _____

ADDRESS:_____CITY:_____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:
❑ History and physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-ray reports	_____
❑ Other: _____	_____

I specifically authorize the release of information relating to:
- ☐ Substance abuse (including alcohol/drug abuse)
- ☐ Mental health (including psychotherapy notes)
- ☐ HIV related information (AIDS related testing)
- ☐ Genetic Testing

X_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care

❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation

❑ Other (please specify): _____

1. I understand that this authorization shall be in force and effect until, at which time this authorization form expires.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____
SIGNATURE OF PATIENT DATE

OR

_____ _____
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE