Authorization for Disclosure of Protected Health Information

Patient Name: _____

Date of Birth _____

Full Address: _____

Maiden/Previous Names: _____

Email Address: _____ **Phone Number:** _____

Release Information From:

Name/Facility:

_____

Address:

_____

City/State/Zip

_____

Phone:

_____

Release Information To:

Name/Facility:

_____

Address:

_____

City/State/Zip

_____

Phone:

_____

Purpose of Release:

❑ Continuing Medical Care ❑ Work Comp ❑ Disability Determination ❑ Personal
❑ Insurance Claim ❑ Application for Insurance ❑ Legal ❑ Other: _____

Delivery Method: Date information desired by: _____

Release Format (Check only 1 option):

1. ❑ Paper via ❑ Mail **OR** ❑ Pick Up **OR** ❑ Fax (*as appropriate*) **Fax # :** _____
2. ❑ USB ❑ Mail **OR** ❑ Pick Up
3. ❑ Email to above email address

Information to be Released:

Service Dates: From: _____ To: _____ **AND** ❑ all future records until authorization expires

❑ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

❑ Discharge Summary ❑ ER Records ❑ History & Physical ❑ Clinic Visit Notes
❑ Psychological Evals/Assmts ❑ EKG / Cardiology Reports ❑ Immunization Records ❑ Operative Reports
❑ Lab / Pathology Reports ❑ Radiology Images ❑ Radiology Reports ❑ Entire Medical Record
❑ Billing Statements ❑ Alcohol/Drug Treatment Records *charge may apply)*
❑ Hospital Claim Form ❑ Clinic Claim Form ❑ Other: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do **not** release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage.I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits. **This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:** _____

Signature: _____ **Date:** _____

Relationship of Person Signing (If not patient): _____