Authorization for Release of Personal Health Information

Instructions: This authorization is made by you for the release of your healthcare information, as indicated. Please complete each section. Sections NOT completed may delay the request of information being released.

SECTION 1- PATIENT INFORMATION			
Name:			Date of Birth:
Address (street, city, state, zip)			
Phone Number(s): Home:	Cell:	Business:	Social Security Number (last 4): **XXX-XX-**

SECTION 2- AUTHORIZED TO REQUEST USE OR DISCLOSURE (FROM)
I request that my medical record information be sent FROM the person(s)/location(s) indicated below.
Organization:
Address (street, city, state, zip):

SECTION 3-AUTHORIZED RECIPIENT TO RECEIVE (TO)			
I request that my medical record information be sent TO the person(s)/location(s) indicated below. If you are requesting **access to your own medical record,** please fill in your personal information.			
Name:			
Address:			
City:	State:	Zip:	
Phone Number(s): Home:	Cell:	Business:	Fax:

SECTION 4- PURPOSE OF THE USER OR DISCLOSURE (E.G, FUTHER CARE, INSURANCE, CLAIM, ATTORNEY INQUIRY, PERSONAL USE, ETC.)

SECTION 5- DISCLOSURE TO INCLUDE			
The following information is authorized for release for the **treatment dates of:**			
This disclosure will include the following types of reports (check all that apply):			
☐ Record Abstract (History and Physical, Emergency Room Record, Lab, Radiology, Operative Report, Pathology Report, Consultation Report, D/C			
☐ Imaging/Radiology report	☐ Operative report	☐ History and Physical	☐ Pathology report
☐ Emergency report	☐ Consultation report	☐ Immunization record	☐ Itemized bill
☐ Progress/Physical notes	☐ Discharge summary	☐ EKG/EEG/EMG report	☐ Entire chart
☐ Laboratory report	☐ Other:		

SECTION-6 HIGHLY CONFIDENTIAL INFORMATION TO BE DISCLOSED
The following highly confidential items must be checked off to be included in the use or disclosure of health information:
☐ HIV.AIDS related health information and/or records (the patient 12 or over must authorize this release)
☐ Behavioral or Mental Health Information and/or Records (release must be witnesses and the patient 12 or over must authorize this release)

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☐ Information about sexually transmitted disease (the patient 12 or over must authorize this release)
☐ Pregnancy (the patient 12 or over must authorize this release)
☐ Birth Control (the patient 12 or over must authorize this release)
☐ Drug/alcohol diagnosis, treatment and/or referral information (the patient 12 or over must authorize this release)
☐ Genetic testing information and /or records
☐ Information about sexual assault/abuse
☐ Information about child abuse and neglect

SECTION-7 AUTHORIZATION EXPIRATION DATE

This authorization is approved for: ☐ This occurrence only ☐ 60 days from the date of Signature Date: _____

☐ 1 year from the date of signature (mental health records only) Date: _____

* Only effective for this occurrence if none is chosen

SECTION-8 PLEASE READ THE FOLLOWING STATEMENT CAREFULLY:

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: 1) action was previously taken in reliance on this authorization: 2) this authorization is obtained as a condition for obtaining insurance coverage: other law provides the insurer with the right to contest a claim under the policy itself.

Authorization: I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled “Disclosed Information To”. I understand that the information to be release may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it, may be subject to re-disclosure by the recipient and is no longer protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment receive payment, or eligibility for benefits.

SECTION-9 SIGNATURE

Signature of Patient/Representative:	Date:
Relationship to patient if signed by representative:	