
## Authorization for Release of Information

I hereby authorize _____
(Entity/Person from Whom Records are Requested)

_____
(Full and Complete Address)

_____
(Office Number and Fax Number, if available)

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name _____ Date of Birth _____ Social Security Number _____

Date(s) of service (if known): _____

Description of information to be released (check all that apply):

| | | |
|---|---|---|
| ____Emergency Room | ____Radiology reports | ____Admission/Registration |
| ____History & Physical | ____Consultation reports | ____Physician's orders |
| ____Laboratory reports | ____Progress Notes | ____Operative records |
| ____Billing records | ____Discharge summary | ____Radiology films |

____Others: _____

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to (check the appropriate category):

____Hospital; _____Physician; _____Insurance Company; _____Attorney; _____Patient; _____Other

Physician Name _____

Address _____

City _____ State _____ Zip _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying in writing at _____.
I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient or legal Representative _____

Relationship to Patient or Legal Authority (attach supporting documentation): _____

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