

Authorization for Disclosure of Health Information

I hereby authorize _____ to release medical information from the records of:

(Name of Facility)

Patient Name: _____ D.O.B.: ____/____/____ SS#: XXX-XX-____

Patient Street Address: _____

City: _____ State: _____ Zip Code: _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check all applicable items to be released):

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Record | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> X-Rays Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Doctor's Orders |
| | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> HIV testing | |
| | <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG/ECG Tests | <input type="checkbox"/> Nurse's Notes | |
| | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Commitment Papers | |

Other (please specify): _____

Purpose Or Need For The Disclosure Is:

Continued Medical Care Insurance Legal Patient's Own Use Other _____

The Information May Be Disclosed To:

Recipient's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____

(Date)

(If no date or event is specified, this authorization will expire one (1) year from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

(Signature of Patient or Personal Representative*)

(Date of Signature)

*If signed by a personal representative, a description of the representative's authority to act is as follows:

Parent Legal Guardian Health Care Power of Attorney
Administrator Executor of Estate Next of Kin Beneficiary