AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider) _____

(2) To disclose the following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ Telephone: _____

Medical Record Number: _____ Dates of Service: _____

(3) Information to be disclosed:

(A) ☐ complete health record(s) ☐ discharge summary ☐ billing records
☐ history & physical ☐ progress notes
☐ x-ray reports ☐ laboratory tests
☐ other (please specify) _____

(B) I understand that this will include information relating to (check if applicable): (*If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.)*

☐ acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
☐ behavioral health services/psychiatric care
☐ treatment for alcohol and/or drug abuse
☐ domestic abuse Initials: _____

(4) At the request of the patient, this information is to be released to: _____

_____

for the purpose of: _____

_____

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I understand that signing this authorization is voluntary. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

Date: _____ Initials: _____

(6) The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for the above disclosure of the above information to the extent indicated and authorized herein.

(7) I may request a copy of this form after signing.

(8) Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in 3 B) and this re-disclosure may no longer be protected by federal or state law.

Initials: _____

Signed: _____
(patient) (this form to be completed before signing) (date)

_____
(legal representative) (relationship to patient – description of authority) (date)

_____
(signature of witness) (relationship to patient) (date)

Note: Release of all confidential information is governed by State and Federal and HIPAA Regulations.
07/15/04