

Authorization for Use and/or Disclosure of Health Information

Important Notice: Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Treatment, payment, enrollment or eligibility benefits will not be conditioned on my providing or refusing to provide this authorization. I hereby authorize the physicians and/or employees of _____ to release information as indicated below:

Release records and information regarding:

Patient Name: _____ DOB: _____ Phone: _____

Address: _____

Release information to:

Name of Receiving Party: _____ Phone: _____

Address: _____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if no date entered.

Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

Redisclosure: I understand that the receiving party may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

I understand there will be a fee involved to produce this information. Please select in which format you are requesting medical records to be produced.

Standard paper copies \$10 clerical fee in addition to \$0.25 per page and cost of postage.

CD (pdf format) \$25 fee and cost of postage.

Specify Records to be disclosed by checking the appropriate boxes:

Medical Information (last 2 years only) -includes progress notes, labs, x-rays, hospital records; excludes HIV, Psychiatric and/or Substance Abuse information

Include OR Exclude: messages, prescription refills, referrals, and requisitions

Medical Information from _____ to _____ or relating to _____

HIV Test Results Psychiatric Record Drug/Alcohol Records Other _____

I request that the health information released pursuant to this authorization be used for the following purposes only:

Changed Insurance

Second Opinion

Personal use

Changed Doctor

Accident / TPL

Unhappy with Care or Service

Moved Out of Area

Legal Case

Other _____

A copy of this authorization is valid as an original.

I have received a copy of this authorization. _____(initial)

Signature of Patient or Patient's Legal Representative

Date

If signed by other than patient, indicate relationship _____

Authorized representative must submit copies of legal documentation supporting assignment of authority.