



Authorization for Release of Health Information

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name (if applicable): _____

My Authorization:

You may use or disclose the following health care information (check all that apply):

- All my health information including, but not limited to, AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and/or drug abuse treatment, if any, unless specifically excepted: _____
- My health information relating to the following treatment or condition: _____
- My health information for the date(s): from: _____ to: _____
- All psychotherapy notes unless specifically excepted: _____
- Other: _____

Information Requested From:

Name (or title) of organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

You May Disclose This Health Information To:

Name (or title) of organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Fax: _____

Reason(S) For This Authorization (Check All That Apply):

- At my request
- Check here only when (physician or clinic) requests the authorization for marketing purposes
- Check here only when (physician or clinic) will get something of value for providing health information for marketing purposes
- Other (specify): _____

This Authorization Ends: On (date): _____

When the following event occurs: _____

My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study, or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation from available from the office; or write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it. I understand that if this office has requested this authorization, I have a right to receive a copy of it.

Patient or legally authorized individual signature.

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, etc.)