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Authorization for Release of Confidential Health Information

1. **Individual information: ……………………………………………………………………………**
   (Name and date of birth of the individual requesting medical records)
   Street address: …………………………… Apt/Suite: ……… City: ……………………………
   State: ……… Zip: ……….. Phone number: ………………………………………………………
2. **Information may be disclosed by: ………………………………………………………………**
   (Name of organization or person releasing information)
   Street address: …………………………… Apt/Suite: ……… City: ……………………………
   State: ……… Zip: ……….. Phone number: ………………………………………………………
3. **Information may be disclosed to: ………………………………………………………………**
   (Name of organization or person receiving information)
   Street address: …………………………… Apt/Suite: ……… City: ……………………………
   State: ……… Zip: ……….. Phone number: ………………………………………………………
4. **What information do you want disclosed? (Choose ONE option)**
   - ○ Information from the most recent 2 years of visits
   - ○ All information from date ……………………………… to date ……………………………
   - ○ Information regarding specific treatment, condition or other (specify):
     ……………………………………………………………………………………………………
5. **Why are you asking for health information to be released? (Choose ONE option)**
   - ○ Attorney
   - ○ Insurance
   - ○ Doctor
   - ○ Medical leave
   - ○ Personal
   - ○ Other (Specify) ……………………………………………………………………………
6. **Authorization:** The medical information to be released as specified above may include any of the following information as it pertains to the request: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. By my initials and signature, I give my specific authorization for this information to be released…………………….**(initial)**
7. **Expiration:** This authorization expires 90 days from the date signed or on the date or event indicated here:…………………………………………………………………………………

Signature: …………………………………… **Date: ……………………………………**

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