AUTHORIZATION TO OBTAIN RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I_____ hereby authorize to:
Patient/Legal Representative

◯ Release Copies of Protected Health information for _____
Patient

◯ Obtain Records

From: Name of Individual, Healthcare Facility or Agency

_____

_____
Address City State Zip Code

Send Records to: _____

_____
Address City State Zip Code

For the purpose of: Continued Treatment _____ Personal Use_____

Patient Communication_____ Other (please Specify)_____

Date(s) of Service: from_____ to_____

This authorization will expire on the following date, event or condition:_____

If I fail to specify an expiration event or condition, the authorization will expire in one year, I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental Health, alcohol use, drug use, HIV and/or AIDS information is confidentially protected by federal and state law where prohibits disclosure without specific written authorization of the undersigned, or as otherwise required by law. I understand that I may select the information from the list below to release by placing my initials by each space provided. The potential for information disclosed pursuant to the authorization is subject to disclosure by the recipient and no longer be protected by the rule. I further understand that under no condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Place your Initials by each item to be released or reviewed:

_____complete Medical record	___All diagnostic Test Results	___Pathology/Operate Reports
Or	___Therapy Records	___Lab only
____Abstract of record	___Consultations/Progress Notes	___Other (Please Specify) ____
	___Radiology only	_____

In addition Place your initials by each specific item (applicable):

___Mental Health	___HIV Testing	___Generic Counseling/Testing Information
___AIDS Information	___Drug Alcohol	

_____ _____
Patient/Legal Representative Date of Authorization

_____ _____ _____
Patient DOB: Patient SS# Identification Shown

Official Use Only: _____Date:_____

_____Name of person releasing Information