

Authorization for Release Of Health Information



Patient name: _____ Date of birth: _____

I authorize release of medical records from: _____ To be released to: _____
Phone/fax: _____ Phone/fax: _____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such information or record exist:

- | | |
|---|---|
| <input type="checkbox"/> Please send the entire medical record (all information) to the above-named recipient | <input type="checkbox"/> Clinician office chart notes |
| <input type="checkbox"/> All hospital records (including nursing records and progress notes) | <input type="checkbox"/> Billing statements |
| <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Emergency and urgent care records | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Diagnostic imaging reports | <input type="checkbox"/> Operative reports |
| | <input type="checkbox"/> Other: _____ |

****The following items must be initialed to be included in the use or disclosure of other health information:**

- ** HIV/AIDS-related information and/or records
- ** Mental health information and/or records
- ** Genetic testing information and/or records
- ** Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal regulations, the information described above may be redisclosed and no longer protected under the Federal Substance Abuse Confidentiality Requirements. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, providing that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked in writing earlier, this authorization will expire 180 days from the date of signing.

Patient or legal representative signature Printed name of signer Date

Witness signature Date