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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ **Date of Birth**:_____

The above named person must indicate when this authorization is to expire:

☐ When information is received ☐ In one year

☐ In six months ☐ In three years

☐ On date_____

The person named above is or has been a patient of:

Name of Person, Provider, or Facility_____

Address_____

Phone_____

Fax_____

The person named above herby authorizes_____to:
Name of Person, Provider, or Facility

☐ Send health information to ☐ Discuss health information with

The person named above authorizes information to be released to representatives of:

Name of Person, Provider, or Facility_____

Address_____

Phone_____

Fax

Scope:

☐ All Medical Records ☐ Other (specify) _____

☐ Medical Records between the dates of _____ to _____
Starting Date Ending Date

☐ All X-rays

☐ X-rays between the dates of _____ to _____
Starting Date Ending Date

Authorization:

_____	_____
Signature of Patient	Date

_____	_____	_____
Signature of Authorized Representative	Printed Name of Authorized Representative	Date

Relationship of authorizing person to patient: □ Parent or Legal Guardian □ Power of Attorney
□ Beneficiary or personal representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this practice. Your revocation will be honored except to the extent that has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices Document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility of benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons, or facilities may be subject to a reasonable charge. Please contact the practice for additional information about applicable copying fees.