AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations
I hereby authorize the use or disclosure of my health information to provide health care as described below.
I understand the information disclosed may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient name: _____
Social Security Number: _____

Persons/organizations providing the information:
_____
_____
_____
_____

Persons/organizations receiving the information:
_____
_____
_____
_____

What specific description of information including date(s). If none noted, all records will be sent:
_____
_____
_____

If applicable, your medical records may include references to Mental Health Information, STD information including HIV Results, or Substance Abuse. Please let us know if you do not want this information released.
_____

Section B: Must be completed only if the healthcare provider has requested the authorization

1. The provider must complete the following statement:

a. Will the healthcare provider requesting the authorization receive financial or any other kind of compensation in exchange for using or disclosing the health information described above?
Yes___ No___

2. The patient must read and initial the following statement:

a. I understand that I will receive a copy of this form after I have signed it.
Patient initials: _____

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing with the form provided to me. The revocation will only be effective from the date it is received in this office and will not apply retroactively.
Patient initials: _____

_____ _____
Signature of patient or patient's representative Date
(Pertinent sections of the Form MUST be completed before signing.)

Printed name of patient's representative: _____
Relationship to the patient: _____