

# Authorization for Disclosure of Protected Health Information

Name:	Date of birth:	Address:

Release From:	Release To:
Address:	Address:
City, State/Zip	City, State/ZIP
Phone	Phone:

**Purpose of Release:**

**Release Format:**

Continuing care \_\_\_\_\_  
 Legal \_\_\_\_\_  
 Personal \_\_\_\_\_  
 Other \_\_\_\_\_

Mail \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Pick up \_\_\_\_\_  
 Other \_\_\_\_\_

**Dates of treatment to be released:** From: \_\_\_\_\_ To: \_\_\_\_\_

**Date Information desired by:** \_\_\_\_\_

**Information to be Released:**

**(Please circle all that apply)**

Clinic notes	History & Physical	ER records	Discharge Summary
EKG Reports	Immunization records	Lab/Path reports	Radiology reports
Radiology Images	Psychological evals	Alcohol/Drug tx records	Entire Medical Record
Other(please specify)			

I authorize release of all alcohol and/or drug treatment, mental health records and HIV treatment records that are part of the records I specified above unless indicated otherwise below.

Do NOT release alcohol/drug treatment, mental health records and HIV treatment records protected under federal law \_\_\_\_\_

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage.

I authorize the facility/provider to disclose medical information to the party identified in the "Release to" section. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

This authorization expires one year from the date of my signature unless I specify a different event, purpose, or alternative expiration date listed here: \_\_\_\_\_

I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy laws(HIPAA) and the recipient of my health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

If this authorization is for marketing by the covered entity, indicate if the covered entity will receive compensation for the use and disclosure of PHI. Please circle. Yes/No

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If signed by person other than patient, specify your legal authority:**

**Legal Guardian**\_\_\_\_\_

**Parent of Minor** \_\_\_\_\_

**Next of Kin** \_\_\_\_\_

**POA for Healthcare**\_\_\_\_\_

Records released by: \_\_\_\_\_

Records released date: \_\_\_\_\_