AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

_____ Name of Patient/Previous Names

_____ Birth Date/Medical Record Number

_____ Street Address

_____ City, State, Zip

Authorizes:

_____ Name of Health Care Provider/Plan/Other

_____ Street Address

_____ City, State, Zip Code

Release of Protected Health Information to:

_____ Name of Health Care Provider/Plan/Other

_____ Street Address

_____ City, State, Zip Code

Information to Be Released:

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Allergy Records
___ Consultations
___ Surgical Reports
___ Hospital Records Including Reports
___ Laboratory Reports
___ **Entire Record**
___ Immunizations
___ X-ray Reports
___ Prescriptions
___ Other (Specify): _____

Purpose for Need of Disclosure: (Check applicable categories)

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Changing Physicians
___ Personal
___ Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect to this Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting _____. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact:_____.
I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____**Date:** _____
(If signed by other than patient, state relationship and authority to do so.)

Witness: _____