

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Date Information Desired By:	Patient Name: _____ Date of Birth _____ Address (including City/State/Zip): _____ Phone Number: _____ Maiden /Previous Names/Nicknames: _____
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Instructions: Fill out form in its entirety. If any section is incomplete, this form may be invalid and the request may not be processed

Release Information From:

Provider/Facility Name:
Address:
City/State/Zip
Phone

Release Information To:

Name/Facility
Address
City/State/Zip
Phone
For continuing care, fax #:

Purpose of Release:

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Disability Determination	
<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Personal	

Information to be Released:

Release Format: <input type="checkbox"/> Paper <input type="checkbox"/> CD/DVD	Release Method: <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up <input type="checkbox"/> Fax (continuing care only)
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Service Dates: From: _____	To: _____
<input type="checkbox"/> Clinic Progress Notes <input type="checkbox"/> Hospital Progress Notes <input type="checkbox"/> History & Physical <input type="checkbox"/> Consultation Notes <input type="checkbox"/> ER Records	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> EKG/Cardiology Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> Other: _____
<input type="checkbox"/> Lab Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Substance Abuse Evals/Assmt	<input type="checkbox"/> Psychological Evals/Assmts <input type="checkbox"/> Immunization Records <input type="checkbox"/> All Records <input type="checkbox"/> Billing Statements

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section titled, "Release information To." I understand that the information to be released may include information regarding mental health, alcohol and drug abuse, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

This authorization will expire one year from the date of signing unless indicated an event or earlier date here: _____

ATTENTION: Please review the information below carefully. If information is missing the request may not be processed

- If the patient is 18 year of age or older, the patient must sign and date the form
- If the patient is 18 years of age or older and lacks capacity to sign, a legally authorized person may sign and date the form. Please indicated your legal authority and include documentation of your relationship:

<input type="checkbox"/> Legal Guardian or Conservator	<input type="checkbox"/> Health Care Agent (Health Care Power of Attorney)
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- If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: Parent Legal Guardian

Signature (required):	Date Signed (required):
Printed Name of Person Signing (if not patient):	