



AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I, _____
(Patient Name – Please Print) (Date of Birth) (Social Security Number)

I hereby Authorize:

To Disclose Information to:

Name: _____ Name: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____

Please release the following medical information on the above referenced patient:

(X) Clinical notes, lab, and x-ray reports related to the following date of service(s) or condition: _____

(X) Entire medical record (X) Behavioral and mental health information

(X) HIV information (X) Substance abuse information

() Any restrictions: (Please List) _____

This disclosure is being made for the following reason(s):

____ Transfer of Care ____ Attorney ____ Personal Use (\$10 fee) ____ Referral
____ Insurance ____ Worker’s Compensation ____ Other (Please describe) _____

I understand that this is authorization is voluntary and I may refuse to sign this authorization. I understand this authorization is subject to revocation at any time by written notification by me except to the extent that the facility which is to make the disclosure has already acted in reliance on it. I understand my signature on this form authorizes the release of my Personal Health Information to the entity listed until revoked by me in writing or in 1 (one) year.

(Date) (Signature of Patient / Legal Representative)

(Witness) (Relationship of Legal Representative to the Patient)

INTEROFFICE USE ONLY

Records Released

Records Received

() Fax () Mailed () Other _____

Date Received: _____

Date Sent: _____ Initials: _____