AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information:

_____

Last Name First Name Middle Initial Date of Birth

_____

Street Address City State Zip Code

I, the undersigned, hereby authorize _____ to release health information to:
Name of Facility/Person

_____ for the purpose of: _____
Name of Facility/Person Reason for Record Request

_____

Street Address City State Zip Code

If transferring records, please state the reason:_____

Date(s) of Service requested: _____

Specific information to be released:

□ Consults
□ Discharge Summary/Instructions
□ Laboratory/Diagnostic Test Results
□ Medical History/Physical Exam
□ Psychiatric/Mental Health/ Substance Abuse Records
□ Medication Records
□ Operative/Emergency Reports
□ Physician Orders
□ Progress Notes
Other_____

□ I request the **entire** medical record be released (including HIV-related information, and re-disclosures from other health care providers) **except** for the information specified below:

_____

I understand I have a right to receive a copy of this authorization upon my request.
I understand that the information disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would be subject to the privacy rules governing that facility.

This release is valid for one year after the date of signature, unless otherwise specified:
_____.

I understand that I have the right to revoke this authorization at any time by submitting a written request to the releasing entity.

Request Date: _____ Copy Received by: _____ Date: _____

Patient's Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____