# Authorization for Disclosure of Health Information

**I hereby authorize** _____ **to release medical information from the records of:**

*(Name of Facility)*

**Patient Name:** _____ **D.O.B.** ____/____/_____ **SS#: XXX-XX-** _ _ _ _

*(MM/DD/YYYY)*

**Patient Street Address:**_____

**City:**_____ **State:**_____ **Zip Code:**_____

**Date(s) of Treatment Requested:** _____

**Information to be disclosed (check all applicable items to be released):**

| | | | | |
|---|---|---|---|---|
| ☐ Medical Records | ☐ History and Physical | ☐ X-Rays Reports | ☐ Progress Notes | ☐ Commitment Papers |
| ☐ Billing Records | ☐ Consultations | ☐ Lab Reports | ☐ Medication Records | ☐ Treatment Plans |
| ☐ Discharge Summary | ☐ Operative Report | ☐ EKG/ECG Tests | ☐ HIV testing | ☐ Doctor's Orders |
| ☐ Discharge Instructions | ☐ ER Record | ☐ Therapy Notes | ☐ Nurse's Notes | |

☐ Other (please specify):_____

**Purpose Or Need For The Disclosure Is:**

☐ Continued Medical Care ☐ Insurance ☐ Legal ☐ Patient's Own Use ☐ Other _____

**The Information May Be Disclosed To:**

**Recipient's Name:** _____

**Street Address:**_____

**City:**_____ **State:**_____ **Zip Code:**_____

**Phone #:**_____ **Fax#:**_____

**Preferred Deliver Method: ☐ Email** _____ **☐ Paper ☐ CD**

*(If no method is specified records may be sent on either paper or CD depending on number of pages reproduced.)*

**My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.**

**I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.**

**I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.**

**This authorization expires on:**_____ **or upon the following event:**_____

*(Date)*

*(If no date or event is specified, this authorization will expire one (1) year from the date of signature.)*

**I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).**

**Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.**

_____ _____

*(Signature of Patient or Personal Representative*)* *(Date of Signature)*

***If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney ☐ Administrator ☐ Executor of Estate ☐ Next of Kin ☐ Beneficiary