Esse Health
Authorization for Release of Medical Information

Patient Name:____ MRN # _______________________
Social Security Number_______________________________ DOB _________________________
1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:
Name:____
Address:____

3. The type and amount of information to be used or disclosed is as follows:
_ Complete Medical Record _ List of Allergies _ X-Ray Reports
_ Physician Progress Notes _ Problem list _ EKG's
_ Immunization Record _ Lab Reports _ Medication list
_ Consultation Reports From:________________________ _ Other (please specify) __________
Dates of Treatment:____

4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released *only* if I indicate my specific consent by checking the appropriate box:
_ Alcohol Abuse _ Mental Health Notes _ Drug and Substance Abuse
_ Testing for presence of HIV-Antibodies and/or treatment of AIDS

5. This information may be released to and used by the following individual or organization:
Name:____
Address:____
For the purpose of:____

6. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date, event or condition:____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand that there may be a charge for costs associated with copying my health information.

____ ____________________
Signature of Patient / Legal Representative (specify relationship to patient) Date

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For Office Use Only

Purpose for Transfer ____Insurance Charge ____Relocation
____Other ____
Date Records Released: ________________________________ Copied By: _____________________

Form #604 Medical Information Release Compliant with HIPAA Regulations
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