AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize the use or disclosure of the above-named individual's health information as described below.

INFORMATION TO BE RELEASED **BY:**	INFORMATION TO BE RELEASED **TO:**
_____	_____
Organization/Person Name	Organization/Person Name
_____	_____
Address City, State, Zip	Address City, State, Zip

TYPE OF MEDICAL INFORMATION TO BE DISCLOSED

□ Complete Medical Record	□ List of Allergies	□ X-ray reports
□ Physician Progress Notes	□ Problem list	□ EKG
□ Immunization Records	□ Lab Reports	□ Medication list
□ Consultation Reports	□ Other (please specify) _____	

□ My health information relating only to the following treatment/condition_____

□ My health information only for the following dates: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby **specifically authorized to release** all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below.

_____

I understand I have a right to cancel this authorization at any time. I understand 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 the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand 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 or event _____. If I fail to specify an expiration date or event, this authorization will expire in six months.

I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand 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 there may be a charge associated with copying my health information.

_____ _____

Signature of Patient/Legal Representative Date