

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: \_\_\_\_\_  
Last First MI Maiden or Other Name

Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Medical Record #: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Service: \_\_\_\_\_

I authorize Dr. \_\_\_\_\_ to use and disclose my protected health information for his/her own purposes of treatment, payment, and health care operations.

I authorize Dr. \_\_\_\_\_ to disclose the following records related to the date above:

- Records:**
- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> All records | <input type="checkbox"/> Medical Records                       | <input type="checkbox"/> HIV/STD                  |
|                                      | <input type="checkbox"/> Diagnostic Records (lab, x-ray, etc.) | <input type="checkbox"/> Drug and alcohol related |
|                                      | <input type="checkbox"/> Treatment Records                     |   |
|                                      | <input type="checkbox"/> Billing/Claims Records                |   |

**Please release these records to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code : \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

**Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.**

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on \_\_\_\_\_

\_\_\_\_\_  
Patient or Legal Representative Signature Date

\_\_\_\_\_  
Print Patient or Legal Representative Name/Relationship