# AUTHORIZATION FOR RELEASE OF INFORMATION

**Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This form must be **completely** filled out.

Patient Name (Print): ______________________________ SSN# _________________________

Phone Number: ________________________________ DOB: _________________________

**Medical Provider to release records:**

________________________________________

Address: ________________________________

City: ______________ State: ______ Zip: ______

Phone Number: __________ Fax Number: __________

**Persons/Organizations receiving the information:**

________________________________________

Address: ________________________________

City: ______________ State: _____ Zip: __________

Phone Number: __________ Fax Number: __________

Specific description of information (including dates):

_____ Entire Chart _____ Chart Notes _____ Radiology Report _____ Labs

_____ Operative Reports _____ Hospital Records _____ Other ______________________________

**Section B: Must be completed only if a health plan or healthcare provider has requested the authorization**

*Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ________ yes ________ no

* I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

* I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of the form after I sign it if I ask for it. Further, I understand there may be a fee for a copy of this information.

**Section C: Must be completed for all authorizations**

* What is the purpose of the use or disclosure? ______________________________________________

* I understand that this authorization will expire on ____/____/_____. Or at the term of __________________________ event. If not specified, this release will expire 180 days from the date signed.

* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

________________________________________ ________________________

Signature of patient or patient's representative Date
(Form MUST be completed before signing)

Printed name of patient's representative: ______________________________________________

Relationship to the patient: ________________________________

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***