Authorization for Release of Medical Information

Patient Name ________________________________ **Date of Birth** _____/_____/______

Information Requested From

Name ____

Address ______________________________City _______________State ____ Zip Code _________

Phone (____) ______________ Fax (____) ______________ Email ______________________

Send Information To

Name ____ Send by ☐ Mail ☐ Fax ☐ Secure Email

Address ______________________________City _______________State ____ Zip Code _________

Phone (____) ______________ Fax (____) ______________ Email ______________________

Any and all of the following Health Information may be disclosed without exception as permitted by this authorization or by law:

☐ Medical Records ☐ Claims/Billing Information ☐ Mental Health Records
☐ Drug/Alcohol Abuse Record ☐ HIV/AIDS Test Results, Diagnosis, Treatment, or other related Information

Patient's Name ____

The above information may be disclosed for the following dates of service:

☐ Any and All Dates of Service ☐ Dates of Service Including: ______________________________

The information may be used only for the following purposes: ______________________________

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I understand that my health care will not be affected if I do not sign this form.

I understand that this authorization will expire on ______________________ or one year from the date of my signature below, whichever is earlier.

— form continued on back

Authorization for Release of Medical Information (cont'd)

Patient Name ____ **Date of Birth** _____/_____/______

I understand that I have the right to receive a copy of this authorization. I understand that this authorization is voluntary and that I may revoke the authorization at any time by presenting my written revocation to the Authorized Discloser listed above. I understand that I do not have a right to revoke the authorization if it was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the insurance policy. I understand that the Authorized Discloser may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, unless otherwise permitted by applicable law. I also understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Signature ____ **Date** _____/_____/______

If not signed by the patient, please indicate the relationship:

☐ Parent or guardian of a minor patient (to the extent minor could not have consented to the care).

☐ Guardian or conservator of an incompetent patient.

☐ Beneficiary or personal representative of a deceased patient.

☐ Other ____

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