

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name : \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I request that my protected health information be disclosed:

To: Recipient Name: \_\_\_\_\_ Address: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax (healthcare provider only): \_\_\_\_\_
From: Sender Name: \_\_\_\_\_ Address: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize the following protected health information to be released from my medical record(s):

Immunization Record
Office Visit Records
Test Result(s) of: \_\_\_\_\_
Itemized Billing Records
Other: \_\_\_\_\_

State and/or federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates of service where appropriate):

Alcohol, Drug, or Substance Abuse Records: [ ] Yes [ ] No Dates: \_\_\_\_\_
HIV Testing and Results: [ ] Yes [ ] No Dates: \_\_\_\_\_
Mental Health: [ ] Yes [ ] No Dates: \_\_\_\_\_
Psychotherapy Records: [ ] Yes [ ] No Dates: \_\_\_\_\_

Covering the period of healthcare from: Specific Date(s): \_\_\_\_\_ to \_\_\_\_\_ OR
All past, present and future encounters/visits

Purpose for requesting information: Legal Insurance Personal Continuation of Care Other (please specify other on line below): \_\_\_\_\_

Disclosure Format (Paper is default if not marked.): US Mail – paper format Fax (healthcare provider only)
E-mail (secure format) E-mail (unsecure format, i.e., Gmail, Yahoo) CD/Flash drive – secure format Other (please specify): \_\_\_\_\_

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to my physician’s office. Revocation will not apply to information that has already been disclosed in response to this authorization.
• Unless otherwise revoked, this authorization will expire on the following date/event/condition: \_\_\_\_\_. If I fail to specify an expiration date/event/condition, this authorization will expire 90 days from the date signed.
• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
• Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by the federal Privacy Rules.

\_\_\_\_\_  
Patient or Authorized Representative Signature Date
\_\_\_\_\_  
Print Name Relationship to Patient (if applicable)

Witness: \_\_\_\_\_ Account # \_\_\_\_\_ Medical Record # \_\_\_\_\_