AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____ to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient name: _____ **Date of birth:** _____

Persons/organizations to receive the information: _____

_____

_____

The specific information to be released/disclosed is specified below:

☐ **All Records –**
☐ **Physician Notes Only –**
☐ **Lab Records –**
☐ **Radiology Records –**
☐ **Other** _____
☐ **Billing Records –**

This information is to be used/disclosed for the following purposes(s) only: _____

_____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

This authorization will expire on _____

_____ _____

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

Printed name of patient's representative (if applicable): _____

Relationship to the patient (if applicable): _____

*** YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT ***