Authorization To Disclose Health Information

Patient Name: _____

Last 4 digits of Social Security #: _____ Date of Birth: _____

Address: _____

(Street) *(City, State)* *(Zip)*

I **authorize** the following individual or office to make the disclosure: _____

Address _____

I **authorize** the use or disclosure of the above named individual's health information as described below:

INFORMATION TO BE RELEASED: (Specify Dates) The type and amount of information to be used or disclosed is as follows: (include dates, if appropriate. Be specific, for example state "lab results from July 1998")

o Office Note Dictation	o Consultation	o Prescriptions
o Test/Procedure	o Laboratory Reports	o Allergy Records
o History & Physical	o X-ray Reports	o Entire Record
o Discharge Summary	o Immunizations	o Other _____

For the Following Dates: _____

This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

Fax #: _____ **Phone #:** _____

for the **Purpose** of _____

ELECTRONIC: Do you prefer an electronic copy? ☐ Yes ☐ No

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, as provided in 45 CFR 164.524. I understand that if I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of the form upon request. I understand that this release also pertains to my medical records concerning treatment, including but not limited to, information regarding treatment for alcohol/drug abuse, sexually-transmitted and/or communicable diseases, including AIDS or human immunodeficiency virus (HIV), and/or psychiatric or mental health problems. I understand that **I have a right to withdraw this authorization at any time.** I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the health information management department of the entity listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the following date / event, or condition specified below.

I understand that authorizing the disclosure of this information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that this request for records will be processed via mail on your behalf unless specified otherwise by you. If I have questions about disclosure of my health information, I can contact The Privacy Officer at 1-888-395-9888.

- **If I fail to specify an expiration date, event or condition, this authorization will be valid one time for the request noted above _____(expiration date or event)**
- **I understand that I am responsible for paying the applicable copy fees, if any. I have the right to an estimate of the fees before receiving a copy of the records.**

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

(If signed by Legal Representative, state relationship and authority to do so) Signature of Witness

Rev. 6/16 Received by: _____ Date: _____