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**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: \_\_\_\_\_ SSN#: \_\_\_\_\_

Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Medical Provider or Class of persons: \_\_\_\_\_ Persons/organizations receiving the information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific description of information (including date(s)):  
\_\_\_\_\_ Dates \_\_\_\_\_ Progress Notes \_\_\_\_\_ Labs \_\_\_\_\_ Operative Reports \_\_\_\_\_ Radiology Report \_\_\_\_\_ Correspondence \_\_\_\_\_  
Hospital Records \_\_\_\_\_ Other Provider Records \_\_\_\_\_ Test Results \_\_\_\_\_ Consultations \_\_\_\_\_ PT Notes \_\_\_\_\_ Entire Chart \_\_\_\_\_ Radiology  
Films \_\_\_\_\_ Billing \_\_\_\_\_ Other \_\_\_\_\_

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

The health plan or health care provider must complete the following:

- \* What is the purpose of the use or disclosure?: \_\_\_\_\_
- \* 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

The patient or the patient's representative must read and initial the following statements:

- \* 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 this form after I sign it. Further, I understand there may be a fee for a copy of this information.

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

The patient or the patient's representative must read and initial the following statements:

- \* I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_.
- \* 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 effect on any actions they took before they received the revocation.
- \* I understand there will be a fee for copying and releasing my records, and that such fee is in accordance with state and federal guidelines.
- \* 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\***