



RELEASE OF PROTECTED HEALTH INFORMATION

To release the personal health information of: PATIENT'S NAME \_\_\_\_\_

Date of Birth \_\_\_\_\_ OR Last Four of Social \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Table with 2 columns: AUTHORIZED FROM, RELEASE TO. Rows include Address, City/State/Zip, and Phone/Fax.

Release the following information:

\_\_\_\_\_ Entire Record OR Specific Dates of Service \_\_\_\_\_

\_\_\_\_\_ Verbal Information - To \_\_\_\_\_

\_\_\_\_\_ Partial Record to include: \_\_\_ Discharge Summary \_\_\_ Consult \_\_\_ Operative \_\_\_ Labs

\_\_\_ Office Notes \_\_\_ H&P \_\_\_ Treatment \_\_\_ Radiology \_\_\_ OTHER \_\_\_\_\_

To the extent any of the following information is contained in the records being released, I specifically authorize the release of such information for the purposes indicated below by initialing before each category:

Initials: \_\_\_\_\_ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented:

Initials: \_\_\_\_\_ drug and/or alcohol diagnosis, treatment, test results and reports and referral information.

Initials: \_\_\_\_\_ mental health treatment information, test results and reports including psychological and psychiatric studies, reports, evaluations and referral information; and/or

Initials: \_\_\_\_\_ venereal disease information.

This authorization will remain in effect:

\_\_\_\_\_ From the date this authorization was signed until \_\_\_\_\_ (not over 1 year)

\_\_\_\_\_ Until the Releasing Entity fulfills the request or you have revoked this authorization

The information released according to your direction may be subject to re-disclosure by the recipient of the information and may no longer be protected by federal or state law. I may refuse to sign this authorization for any reason and the Releasing Entity may not condition my treatment on whether I sign this authorization unless my treatment is research-related or I am to receive healthcare solely for the purpose of creating protected health information for disclosure of the Recipient identified in this authorization. I have the right to revoke this authorization in writing at any time. The revocation will be effective immediately upon the Releasing Entity's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Releasing Entity in reliance on this authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorization above Releasing Entity to use or disclosure my health information in the manner described above.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, state Relationship to Patient \_\_\_\_\_

