

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ (print name) authorize the following health care provider and/or organization to disclose and/or use the following protected health information to the designated person and/or organization for the purpose(s) listed below.

<p><b>Information disclosed by:</b></p> <p>_____</p> <p>(name of health care provider/organization)</p> <p>_____</p> <p>_____</p> <p>(address)</p> <p>_____</p> <p>(facsimile number) _____ (phone number)</p> <p><b>Disclose the following information:</b></p> <p>___ medical record</p> <p>___ billing record</p> <p>___ Other: (please specify)</p> <p>___ <b>To be mailed</b></p> <p>___ <b>To be picked up by</b> _____</p> <p>___ <b>To be sent by facsimile</b></p>	<p><b>Information received by:</b></p> <p>_____</p> <p>(name of person or organization)</p> <p>_____</p> <p>_____</p> <p>(address)</p> <p>_____</p> <p>(facsimile number) _____ (phone number)</p> <p><b>The information is disclosed for the following use(s):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>I do ___ do not ___</b> consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.</p> <p><b>I do ___ do not ___</b> consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV(AIDS).</p> <p><b>I do ___ do not ___</b> consent to the disclosure of substance/alcohol abuse evaluation/treatment.</p>	

**This authorization shall expire:** \_\_\_\_\_  
 (expiration date or event)

**I understand the following:**

1. I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the health care provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or my eligibility for benefits will not be affected if I do not sign this Authorization.
3. Any information disclosed by this authorization to any person/organization not a health care provider or health plan covered by federal and state privacy regulations could be re-disclosed by the recipient and not longer protected by those regulations.
4. I am entitled to receive a copy of this signed authorization.

\_\_\_\_\_ (signature of the authorizing individual) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (date signed)

\_\_\_\_\_ (address) \_\_\_\_\_ (contact phone number/s)

\_\_\_\_\_ (signature of personal representative with description of authority to act on behalf of the patient) \_\_\_\_\_ (date signed)