

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 purposes(s) listed below.

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