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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
 WE ASK THAT YOU MAIL RECORDS IF NUMBER OF PAGES EXCEEDS 10**

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

Telephone: _____ Social Security No.: _____

❖ I authorize medical information to be released: (Complete name & address required.)

To: _____ From: _____

❖ **This authorization applies to the information initialed below:**

- | | | |
|--|---|--|
| <input type="checkbox"/> Complete Record (<i>All Info</i>) | <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Mental Health Info. | <input type="checkbox"/> HIV/AIDS Info. |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> Lab Results: _____ | |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> X-ray & Imaging: _____ | |
| <input type="checkbox"/> Allergy List | <input type="checkbox"/> Other: _____ | |

❖ **Purpose of disclosure: (Check all that apply.)**

- Changing Physicians Moving Changing Insurance Other: _____

❖ This authorization is valid until ____/____/____ (Specify a date up to one year from date of signing.)
MM DD YY

Governances of Disclosure

The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of privacy of this information once it has been disclosed to another party.

You may revoke this authorization in writing at any time except to the extent that our offices have already acted on this authorization. To do so, submit a written request to your physician at the address above.

You may refuse to sign this authorization. Your refusal may not deny your treatment at our offices.

You may inspect or copy the information disclosed under this authorization for personal use. Your medical records may contain information that only a physician can interpret. To prevent any misinterpretation of this information you should contact your physician regarding any entries in question.

 Patient's Printed Name

 Date

 Parent or Legal Guardian's Printed Name

 Parent or Legal Guardian's Signature