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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: _____

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

To: _____ From: _____

_____ _____

_____ _____

❖ **This authorization applies to the information <u>initialed</u> below:**

___ Complete Record ***(All Info)***	___ Drug/Alcohol Treatment	___ Genetic Testing
___ Medical History	___ Mental Health Info.	___ HIV/AIDS Info.
___ Billing Records	___ Lab Results: _____	
___ Immunization Records	___ X-ray & Imaging: _____	
___ Allergy List	___ 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