Physician's Practice Name
Address
Phone Number

Authorization for Release of Health Care Information

I, __________ (patient name) __________ Date of Birth ____________________

Maiden Name (if applicable) ______________________________

Authorize: Name of Practice ______________________________
Address ______________________________
City ________________ State ________ Zip Code ________

To Release/Disclose the specified information noted below to:

Name ______________________________
Address ______________________________
City ________________ State ________ Zip Code ________

My health care records from ____ (date) ____ to ____ (date) ____ or my entire health care record. (circle **entire health care record** if that is your request)

Purpose of requested disclosure:
At the Request of the Individual ☐ Other: ________________________
(Please Specify)

Release only: (write in specific parts of the record: i.e., lab reports, physician notes for date or dates)

____
____
____
____

Circle "Yes" if you want the following information released.
Circle "No" if you do not want it released.

1. **Alcohol or drug dependency, evaluation, diagnosis, or treatment records. Yes No**
2. **Mental health evaluation and treatment records, except psychotherapy notes (I understand that I have the right to review this information under supervision before it is released and I hereby inform you that I do not wish to review that information). Yes No**
3. **HIV/AIDS test results, diagnosis, status, or treatment records. Yes No**

I understand that information disclosed under this authorization might be re-disclosed by the recipient, and that any such re-disclosure may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization at any time. I understand I cannot revoke this authorization if ____ (name of Physician Practice) ____ has taken action on

the authorization. Authorization will be considered inactive when ________(name of Physician Practice)___________ receives a request in writing to revoke authorization.

I understand that I may refuse authorization to release all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

This authorization for release is effective for the release of the medical information mentioned above to the named recipient only.

This authorization will expire on ________________ or upon the following event _____________
____

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that I have the right to receive a copy of this authorization.

____	________________________
Signature of Patient	Date signed
____	________________________
Signature of Legal Representative	Date signed

Check which of the following applies regarding Legal Representative:

___ Legal Guardian
___ Executor of Estate
___ Health Care Power of Attorney