**(PLACE PATIENT ID LABEL HERE)**

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name Date of Birth

Address City, State, Zip Code

Home Phone Number Work Phone Number

# RELEASE OF INFORMATION TO:

Name/Organization: Address:

City, State:

Zip Code:

Telephone #:

Fax #:

# INFORMATION TO BE DISCLOSED COVERING THE FOLLOWING PERIOD(S): (Must be Specific)

Specify Dates of Treatment:

# PURPOSE OR NEED FOR THE DISCLOSURE IS:

Continued Care Third Party/Insurance Review School Registration

Legal Consultation Benefits Assignment Camp Registration

Patient’s Own Use Other:

# INFORMATION TO BE RELEASED:

Designated Record Set/Abstract Discharge/Clinical Summary Immunization Record Operative Procedure Report Consultation Report(s) History & Physical Report

Laboratory Report Pathology Report Radiology Report

Emergency Record Other: Entire Medical Record for Visit(s) specified above

# EXPIRATION DATE:

Specify Date, event, or condition upon which this consent will expire unless revoked at an earlier date/time.

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Mental Health Procedures Act, 1976 and the Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at anytime by written, dated communication to the recipient and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, the recipient cannot prevent re-disclosure.

**I understand that any information disclosed in response to this request will not include information related to my treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse unless specifically checked below. An authorization for psychiatric care/treatment notes may not be combined with any other general release of information request.**

**AIDS/HIV Information**

**Psychiatric Care/Treatment**

**Treatment for Drug and Alcohol Use/Abuse**

AM

PM

Patient’s Signature Patient’s Printed Name Date of Time Authorization

AM

PM

Signature of Parent / Legal Guardian / Printed Name of Parent / Legal Guardian / Date of Time Legal Representative Legal Representative Authorization

Relationship to Patient

AM

PM

Witnessed By Witness Printed Name Date Time

|  |  |
| --- | --- |
| Patient Label (Name and Medical Record #) | **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION** |
| **Patient’s Name: Date of Birth: Address:**  **Home Phone: Work Phone: I hereby revoke the authorization generated by me.**  **I understand that this revocation will not be valid where the recipient has already**  **acted in reliance upon my authorization:**  **This revocation applies to healthcare encounters of:**  **Specify Dates:**    **Patient’s Signature: Date: Guardian/Legal Representative: Relation to Patient: Date: Instructions to Patient (or Personal Representative):**  **Mail or fax this form to the site of your original request/authorization to release your**  **protected health information.**  **A copy of this Written Notice of Revocation shall be placed in the patient’s Medical Record. Date Received by Recipient:** | |

