AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

________________________________BD:______________SS#________________
(PRINT NAME OF PATIENT)

Information to be released from:
Name of Provider/Organization-____

Address____

Phone Number-_______________________ Fax Number-_______________________

Information to be sent to:
Name of Provider/Organization-____

Address____

Phone Number-_______________________ Fax Number-_______________________

Information to be released: (Please Check One)-
_____ The most recent 2 years of pertinent information. (Chart notes, labs, x-rays, and special tests)
_____ All medical records
_____ Specific Information (Please specify)-____

____

Purpose for which information is being used: (Please Check One)-
____Attorney ____Insurance ____Changing Doctors____ Personal ____ Referral

Patient Authorization-
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
Please initial the following to have the information excluded from the records-
____Drug/Alcohol abuse/treatment diagnosis____HIV/AIDS Diagnosis/treatment/testing
____ HIV/AIDS Diagnosis/treatment/testing ____Sexually Transmitted Disease

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients at the facility where you information is being released. I understand that once the health information I have authorized to be disclosed reaches the recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. This authorization will EXPIRE 90 days from date signed.

Signature:____________________________________Date:______________________
(Patient, Guardian, or Authorized Representative*)
[Please provide documents to prove authority to sign on behalf of patient]
Possible copying fee required.