Authorization for Release of Health Information

1. Patient Information:	
Patient Name (Print):	Date of Birth:
Patient Address (Print, Include Apt Number):	Telephone Number:
	Email Address:

2. Name, Address, and Telephone Number of Health Care Provider to RELEASE this Information:	
Name:	Address:
Phone:	

3. Name, Address, Telephone, Fax Number and Email of Person(s)/Entities to Whom the Information will be SENT:		
Name:	Address:	
Phone:	Fax:	Email:

4. Specific Information to be Released:

□ Entire Medical Record (including, but not limited to, clinical records, patient histories, billing records, office notes, test results, radiology studies, films, and insurance records.)

□ Medical Record from _____ to _____
(insert date) (insert date)

□ Other (Please Specify): _____

The following types of information will NOT be released unless you or your authorized representative initial in the appropriate spaces provided below:

_____ Alcohol and/or Drug Treatment Information _____ Mental Health Treatment Information

_____ Genetic Testing Information _____ HIV-Related Information

5. Authorization to Discuss Health Information:

_____By initialing here, I authorize the healthcare provider listed in Part 2 of this Authorization (above) to discuss my health information with the following person or entity: _____
(Name of Person or Entity)

6. Reason for Release of Information:	7. Date or Event on Which this Authorization Will Expire*:
□ At the Request of the Individual □ Other (Please Describe): _____	*(Ex: "One year from the date this Authorization is completed" or "Until conclusion of the litigation.")

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with applicable law, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL AND DRUG ABUSE, GENETIC TESTING, MENTAL HEALTH TREATMENT (except psychotherapy notes), and HIV-RELATED INFORMATION only if I place my initials on the appropriate line in Part 4 above. In the event my health information includes any of these types of information, and I initial the appropriate line in Part 4 above, I specifically authorize the release of such information to the person/entity indicated in Part 3.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I have the right to revoke this Authorization at any time by writing to the health care provider listed above in Part 2. I understand that I may revoke this Authorization except to the extent that action has already been taken in reliance on this Authorization.
4. 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.
5. Information disclosed under this Authorization might be redisclosed by the recipient (except as noted above regarding the release of certain types of information), and this redisclosure may no longer be protected by federal or state law.

Patient/Agent/Relative/Guardian* (Signature):_____ Date:_____

If not the patient, name and contact information of person signing this Authorization (Please Print): _____

If not the patient, authority to sign on patient's behalf (Please Print): _____