

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR MARKETING (Please Print)

Date:	I HEREBY REQUEST AND AUTHORIZE: <i>(Name of Practitioner or Clinic)</i>	TO RELEASE HEALTH INFORMATION for Marketing Purposes
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PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	Birth date:	Sex : <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security:	
City:	State:	ZIP Code:	Home phone :	Cell phone :

I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION (CHECK ALL THAT APPLY)

All Health Information in my medical records
 Health Information relating only to the following treatment or condition: _____
 Health Information only for the following Dates: _____

YOUR HEALTH INFORMATION WILL BE USED FOR THE FOLLOWING PURPOSES

(Please Initial Each to Request Release)

Purpose 1:	Initial:
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Purpose 2:	Initial:
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The Practitioner/Clinic requesting this authorization will will not receive financial or in-kind compensation from a third party in exchange for the use or disclosure of your health information authorized for release by you.

DISCLOSE THIS INFORMATION TO THE FOLLOWING PERSON OR ORGANIZATION

Name of Person or Organization:		Phone:	
Street Address:	City:	State:	Zip:

AUTHORIZATION EXPIRATION DATE

90 Days from the date signed
 On the following date: _____
 When the following event occurs: _____

YOUR RIGHTS

- I understand that I do not have to sign this authorization.
- I understand that my care or payment for my care will not be affected if I do not authorize this use.
- I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by those who have relied upon this authorization.
- Once health care information is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

Patient/Authorized signature:	Date:
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If signed by person other than patient print Name of Authorized Person and relation to patient and authority to authorize:

FOR OFFICE USE ONLY

Name and Title of Practitioner/Person who requested this authorization from patient:

Signature of Practitioner/Person who requested this authorization from patient: