

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (Please Print)

Date:	I HEREBY REQUEST AND AUTHORIZE: <i>(Name of Practitioner or Clinic)</i>			TO RELEASE HEALTH INFORMATION:	
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)					
<input type="checkbox"/> All Health Information in my medical records		<input type="checkbox"/> Health Information relating only to the following treatment or condition:		<input type="checkbox"/> Health Information only for the following Dates:	
SPECIFIC PATIENT AUTHORIZATION REQUIRED					
<i>(The Following Types of Information Require Your Specific Authorization – Please Initial Each to Request Release)</i>					
HIV/AIDS _____		Sexually transmitted disease _____		Mental Health _____ Drug/Alcohol Abuse _____	
MINORS —A minor's signature is required in order to release the following: • information relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older) • alcohol, drug abuse and/or mental health conditions (age 13 and older)				Minor Name (Printed)	
				Minor Signature:	
PURPOSE FOR THE DISCLOSURE (check all that apply)					
<input type="checkbox"/> Legal Proceedings		<input type="checkbox"/> Insurance Benefits		<input type="checkbox"/> Patient Use	
<input type="checkbox"/> Employment		<input type="checkbox"/> Other:			
DISCLOSE THIS INFORMATION TO THE FOLLOWING PERSON OR ORGANIZATION					
Name of Person or Organization:				Phone:	
Street Address:	City:			State:	Zip:
AUTHORIZATION EXPIRATION DATE					
Note: Authorizations for employment or to a financial institution can only be effective for a maximum of 90 days from the date signed by you.					
<input type="checkbox"/> 90 Days from the date signed		<input type="checkbox"/> On the following date:		<input type="checkbox"/> When the following event occurs:	
YOUR RIGHTS					
<ul style="list-style-type: none"> • I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party. • 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. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form (A form is available from us) or write a letter to us. • 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:	
<i>If signed by person other than patient print Name of Authorized Person and relation to patient and authority to authorize:</i>					