

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

◇ File Only/ Do Not Send Records

1. Patient information

First name _____ Middle name _____ Last name _____

Patient date of birth ___ / ___ / ___ Previous name(s) _____
MM DD YYYY

Home address _____

City _____ State _____ Zip code _____

Daytime phone _____ E-mail address (optional) _____

2. I am requesting health information be released from at least one of the following:

Organization(s) name _____

Specific health care facility or location(s) _____

Specific health care professional's name(s) _____

3. I am requesting that health information be sent to:

Organization(s) name _____

And/or person: First name _____ Last name _____

Mailing address _____

City _____ State _____ Zip code _____

Phone (optional) _____ Fax (optional) _____

Information needed by (date) ___ / ___ / ___ (optional)
MM DD YYYY

4. Information to be released:

Important: indicate only the information that you are authorizing to be released.

___ Specific dates/years of treatment _____

___ All health information

OR to only release specific portions of your health information, indicate the categories to be released:

___ History/Physical

___ Laboratory report

___ Emergency room report

___ Surgical report

___ Medications

___ Other information or instructions

The following information requires special consent by law. Even if you indicate **all health information**, you must specifically request the following information in order for it to be released:

___ Chemical dependency program

___ Psychotherapy notes

5. Reason(s) for releasing information

- Patient's request
- Review patient's current care
- Treatment/continued care
- Insurance application
- Legal
- Appeal denial of Social Security Disability income or benefits
- Other (please explain) _____

I understand that if the person(s) and/or organizations listed on the reverse are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of the authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your Rights with Respect to This Authorization

Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed on the reverse side who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. *(As a provider or Health Plan, the rule permits you to condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on the signing of this authorization in the following circumstances:*

- (a) a health care provider may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research;*
- (b) a health plan may condition enrollment in the health plan or eligibility for benefits on the provision of an authorization required prior to enrollment in a health plan if:*
 - a. the authorization is for the health plan's eligibility or enrollment determinations or for its underwriting or risk rating determination and*
 - b. the authorization if not for the use and/or disclosure of psychotherapy notes;*
- (c) an entity subject to the Rule may condition the provision of health care that is solely for the purpose of creating health information for disclosure to a third party on the provision of an authorization for the disclosure of health information to such third party.*

If you wish to make such conditions, you must include a description of these circumstances upon signing of this authorization.)

Right to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Medical Records Supervisor. I am aware that my withdrawal will not be effective as to uses and/or disclosures of health information that the person(s) or organization(s) listed on reverse have already made in reference to this authorization.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:

Date / / Or specific event _____
MM DD YYYY

Patient's signature _____ Date / /

Or legally authorized representative's signature _____ Date / /

Representative's relationship to patient (parent, guardian, etc.) _____