Authorization to Release Health Information

I, _____, hereby authorize _____ (the "Center") to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____
Address: _____ Patient's Phone: _____
_____

1. The information is to be disclosed to the following persons or organizations:
   Name:_____
   Address:_____
   _____

2. Purpose. The purpose of the use or disclosure is:
   ☐ At the request of the patient
   ☐ Other:
   _____
   _____

   If the purpose is for marketing, will the Center receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*:

   ☐ The following medical records:

❑ Discharge summary	❑ Progress notes
❑ Lab results	❑ Photographs, videotapes, or other images
❑ History and physical exam	❑ Mental or behavioral health records
❑ Consultation reports	❑ Psychotherapy notes
❑ X-ray reports	❑ Genetic test results
❑ HIV/AIDS test results and treatment	❑ Entire medical record
❑ Alcohol and drug treatment records	❑ Summary of treatment
❑ Operative record	❑ Other (specify):

   ☐ The following billing and payment information:
   _____
   _____

   ☐ Other information:
   _____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Center. However, the revocation will not have any effect on any uses or disclosures the Center may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Center will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.
☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of _____.

Signed this _____ day of _____, 200__.

Signature: _____
Print name: _____
Address: _____
_____
Phone No: _____

Witness: _____
Print Name: _____
Date: _____

(ONE COPY TO BE RETAINED BY THE REQUESTING PARTY)

_ _

For Office Use Only:
Date received: _____ Expiration date: _____

How was identity verified? _____ Copy made? ☐ Yes ☐ No
How was authority verified?: _____ Copy made? ☐ Yes ☐ No

By: _____ Title: _____Date: _____