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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Date:

Patients Name:_____ DOB:____/____/_____
Last First MI

INFORMATION TO BE RELEASED ***BY:***	INFORMATION TO BE RELEASED ***TO:***
_____ ORGANIZATION / PERSON NAME	_____ ORGANIZATION / PERSON NAME
_____ STREET ADDRESS	_____ STREET ADDRESS
_____ CITY, STATE, ZIP	_____ CITY, STATE, ZIP
_____ PHONE _____ FAX	_____ PHONE _____ FAX

"I HEREBY AUTHORIZE THE ABOVE REFERENCED DOCTOR/HOSPITAL TO PROVIDE USE OF OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (INFORMATION PERTAINING TO MY MEDICAL RECORDS AND/OR FINANCIAL RECORDS) AS INDICATED BELOW."

FOR DATES OF TREATMENT FROM: _____ TO: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED:_____

REASON FOR REQUESTED USE OR DISCLOSURE:
TRANSFER OF HEALTH COVERAGE____ PERSONAL USE____ FORM COMPLETION____ REFERRAL___
CHANGE IN HEALTH CARE PROVIDER____ OTHER EVENT_____

- **RECIPIENT OF PHI WILL NOT RE-DISCLOSE THE INFORMATION EXCEPT AS REQUIRED BY LAW.**
- **PROVIDER WILL NOT CONDITION THE PROVISION OF CARE OF RECEIPT OF BENEFITS ON THE SIGNING OF THIS AUTH.**
- **PATIENT WILL RECEIVE COPY OF THIS AUTHORIZATION**
- **PATIENT WILL HAVE THE RIGHT TO REVOKE AUTHORIZATION IN WRITING.**
- **NOTICE WILL BE GIVEN TO PATIENT IF PRACTICE GETS ANY PROFIT FROM RELEASING RECORDS, E.G. (CASE STUDIES THAT PAY FOR PATIENT INFORMATION.**

TO BE READ AND SIGNED BY PATIENT:
I UNDERSTAND THE FOLLOWING:

1. **I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO THE PRACTICE.**
2. **I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF THE PRACTICE HAS ALREADY TAKEN ACTION UTILIZING THIS AUTHORIZATION OR IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE.**
3. **THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT BASED ON MY SIGNING THIS AUTHORIZATION.**
4. **I AM SIGNING THIS AUTHORIZATION FREELY AND UNDER NO PRESSURE FROM ANY INDIVIDUAL TO DO SO.**
5. **THE INFORMATION DISCLOSED IN THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE PRACTICE AND NO LONGER PROTECTED BY FEDERAL LAW.**
6. **I ACKNOWLEDGE THAT I HAVE HAD AN OPPORTUNITY TO REVIEW THIS AUTHORIZATION AND UNDERSTAND THE INTENT AND USE.**
7. **I WILL RECEIVE A COPY OF THIS COMPLETED AND SIGNED AUTHORIZATION FORM.**

PATIENT SIGNATURE_____DATE_____

SIGNATURE OF PATIENT'S REPRESENTATIVE_____RELATIONSHIP_____DATE_____